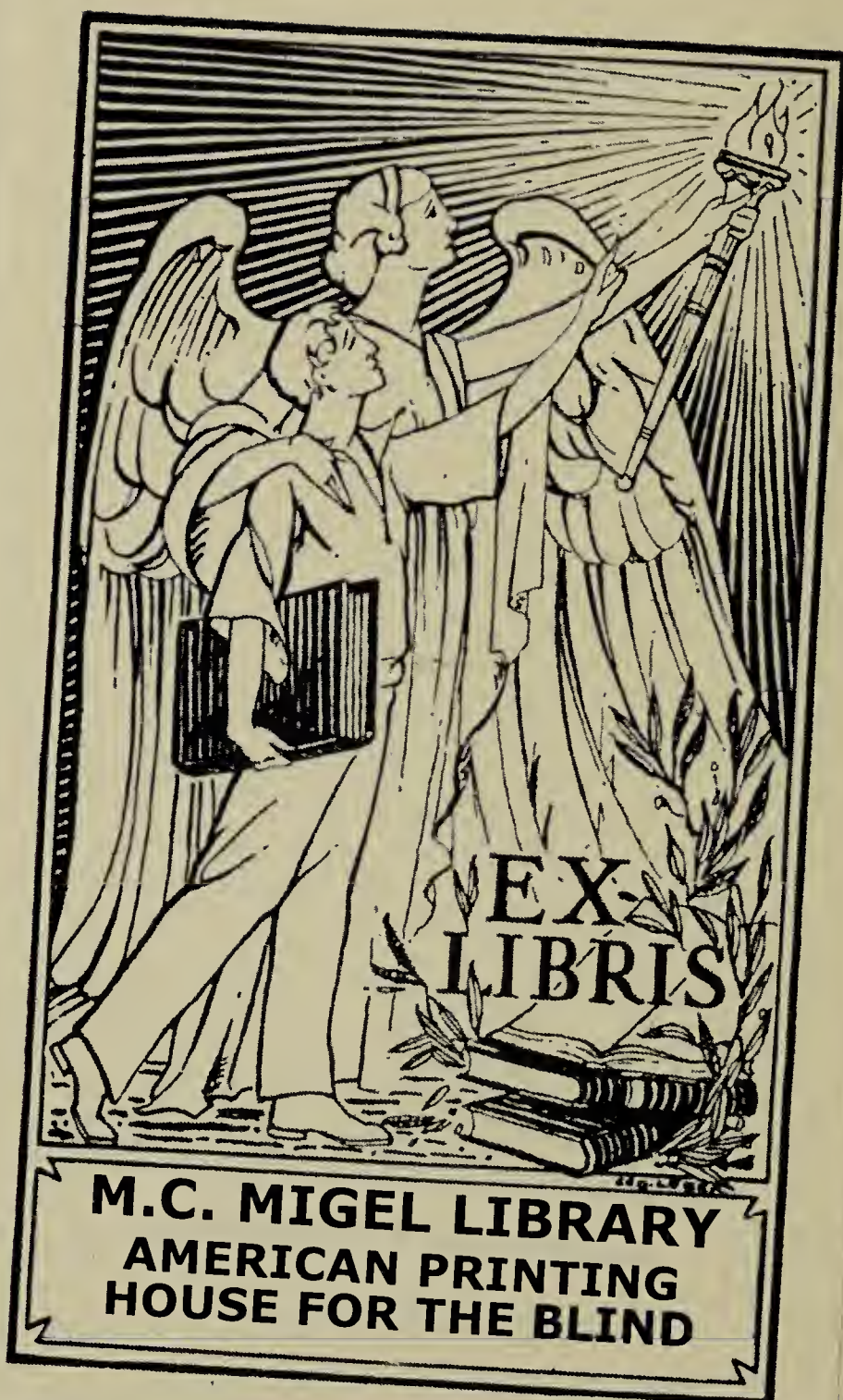


Vocational
Counseling
with the
Physically
Handicapped



Lloyd H. Lofquist



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Vocational Counseling
with the
Physically
Handicapped

THE CENTURY PSYCHOLOGY SERIES

Richard M. Elliott, *Editor*

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Vocational Counseling
with the

PHYSICALLY
HANDICAPPED

Lloyd H. Lofquist
University of Minnesota

New



York

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Library of Congress Card No. 57-5270

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To
My Parents

Foreword

Vocational psychology and vocational counseling at the University of Minnesota have a history extending back to the early 1920's. Interest in the vocational counseling of the physically handicapped has an equally long history in this university. Thus it is no accident that the present volume is an offshoot of developments at Minnesota.

The author, Lloyd H. Lofquist, now associate professor of psychology at the University of Minnesota, was formerly chief of the Vocational Counseling Service at the Veterans' Administration Hospital in Minneapolis. He brought to this position fifteen years of experience. He was a graduate student when he served as a research assistant from 1940 to 1942 in the Minnesota Employment Stabilization Research Institute in its study of the problems of employment, unemployment, and relief in the city of St. Paul. He then served in the U. S. Army during World War II as a personnel psychologist. After the war, he returned to Minnesota to become a vocational counselor of veterans. Since 1951 he has specialized in the counseling of the physically handicapped.

The present volume is the first book to deal systematically with this subject. It is based on a scholarly and intimate knowledge of a rapidly expanding literature combined with a decade of counseling experience with the physically normal and the physically handicapped veteran. Although the author draws heavily on his VA hospital experience, the book will prove of great value to rehabilitation counseling psychologists, whether they are working in a hospital setting, in the testing and counseling division of state employment services, or in state vocational rehabilitation services. The principles

and practices set forth will prove to be of genuine practical value both to those counselors now in service and to the increasing number of graduate students who are being trained in graduate programs two, three, and four years in length as preparation for professional careers in this field.

The writer of this foreword is proud that he had a hand indirectly in the preparation of this book. First, as a co-director of the St. Paul study in which Dr. Lofquist participated most effectively, and, second, as Dr. Lofquist's major adviser for the M.A. and Ph.D. degrees. I am confident that Dr. Lofquist's contribution will be welcomed not only by those especially concerned with rehabilitation work but by those engaged in the vocational counseling of physically normal persons in schools, colleges, social service agencies, public and private employment agencies, and in business and industry. In a real, though somewhat more specialized sense, this book may be regarded as a companion volume to Dr. Leona Tyler's *The Work of the Counselor*, which has enjoyed wide use as a practical guide for the school and college counselor.

DONALD G. PATERSON
University of Minnesota

Preface

Interest in the subject of this book stems from the writer's experiences as a vocational counselor, working with the problems of disabled veterans in the St. Paul Regional Office of the Veterans' Administration and in the Minneapolis Veterans' Administration Hospital.

The writer felt that there was need for an analysis of information available on disabilities and medical conditions and an integration of this information with the principles and techniques of vocational counseling, placing particular emphasis on the applicability of such information and techniques to the work of the hospital and rehabilitation counselor. This book represents an attempt to meet that need.

In preparing this study, the writer found it necessary to draw heavily on his own experiences. He does not, however, presume to answer all the problems in counseling with disabled individuals and patients or to have called attention to all the useful references in the literature. Although it is hoped that this book will provide useful information for counselors, the writer hopes that it will also contribute to their greater awareness of available literature and to stimulation of thought, research, and interchange of ideas in hospital and rehabilitation counseling. There is much still to be done in the large area of rehabilitation counseling. This is a beginning effort at integration of materials for a limited number of disability areas.

It was felt necessary to limit discussion in the body of the book to certain selected disability areas, and the reasons for this are discussed in Chapter 9. Some additional hints that may prove useful for counselors when working with patients

in other disability areas are given in briefer form in Appendix A. Although the writer's counseling experiences have been mainly with hospital patients and disabled veterans, it is felt that much of what is discussed in this book has applicability for readers active in other types of rehabilitation counseling.

Frequent references have been made to the medical literature in an effort to provide the vocational counselor with examples of information that should help him to work more effectively with the patient and with the physician. Complete descriptions of medical diagnostic and treatment procedures, however, have not been attempted. To do this without medical training would be presumptuous.

The writer wishes to thank Professor D. G. Paterson for training and inspiration in vocational counseling and for his many valuable suggestions for planning and implementing this book.

Professors C. Gilbert Wrenn and Ralph F. Berdie of the University of Minnesota critically reviewed the manuscript in its preliminary form, and the writer is indebted to them for their valuable suggestions on both content and form. The encouragement and skill of the editors of this series, Drs. Richard M. Elliott and Kenneth MacCorquodale, are greatly appreciated.

The writer also wishes to thank Dr. John A. Seaberg, manager of the Minneapolis Veterans' Administration Hospital, Dr. A. Falk, director of Professional Services of the Minneapolis Veterans' Administration Hospital, and Dr. Robert S. Waldrop, chief of Vocational Counseling Service, Veterans' Administration Department of Medicine and Surgery, for making it possible to work in a hospital vocational counseling situation where initiative and progress in developing procedures and good interpersonal relationships are possible. It should be made clear, however, that the opinions in this book are not expressions of official policy of the Veterans' Administration or the Minneapolis Veterans' Administration

Hospital. The views set forth here are the author's own, although they have been greatly influenced by discussions with fellow counselors, counseling psychology trainees, and rehabilitation workers in Minnesota, for which the author is grateful.

Mention must also be made of the rich and challenging counseling relationships with disabled veterans and patients the writer has been fortunate to experience in the last ten years. The illustrative case studies presented in the book are drawn from these counseling experiences. Names of patients, places, and other identifying data have, of course, been omitted.

Special mention is due the writer's wife for her encouragement, patience, and assistance during the preparation of this book.

Finally, the courtesy of the following agencies, associations, journals, and publishers is acknowledged for permitting quotations and reprinting from their publications: American Cancer Society, Inc., American Medical Association, American Personnel and Guidance Association, American Psychological Association, Appleton-Century-Crofts, Inc., A. S. Barnes & Company, Inc., Cancer, Columbia University Press, Family Service Association of America, Harper & Brothers, Harvard University Press, Industrial Medicine and Surgery, Institute for the Crippled and Disabled, The International Council for Exceptional Children, The Journal of Bone and Joint Surgery, Journal of Clinical Psychology, Journal of Counseling Psychology, Lea & Febiger, J. B. Lippincott Company, McGraw-Hill Book Company, Inc., Prentice-Hall, Inc., The Psychological Corporation, The Ronald Press Company, W. B. Saunders Company, Science Research Associates, Sheridan Supply Company, Social Science Research Council, Springer Publishing Company, Inc., Testscor, Charles C. Thomas, Publisher, University of Chicago Press, University of Minnesota Press, U. S. Government Printing Office, U. S. Department of Health, Education, and

Welfare, Office of Vocational Rehabilitation, U. S. Department of Labor, Bureau of Employment Security, U. S. Department of Labor, Bureau of Labor Statistics, and The Williams & Wilkins Company.

L. H. L.

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PART ONE

Introduction



1

The Need for an Analysis of Rehabilitation Counseling

CURRENT EMPHASES IN REHABILITATION COUNSELING

Interest and activity in the area of vocational counseling in hospitals is progressing rapidly. Super (131, p. 8), among others, has stated his belief that the field of counseling psychology is still evolving and that important developments will take place in the next few years, especially in connection with rehabilitation work. As Veterans' Administration hospitals face up to the mounting load of veterans from the first and second world wars and the Korean conflict, and as the increasing age of these patients promises greater patient responsibilities for the future, the need for trained vocational psychologists who can help patients to plan a productive future becomes apparent. The patient plan must be compatible with present and anticipated physical conditions and realistic enough to capitalize on patient abilities, aptitudes, and interests, in relation to occupational and labor-market conditions. For effective results, planning with patients requires the resources of many people. ✓

To best utilize all resources, there has been increasing emphasis on the team concept and the total rehabilitation idea in hospital methodology. There is growing recognition of the fact that large expenditures of professional time and money in treatment are of little ultimate value unless the

patient has found it possible to implement a vocational plan that is consonant with his physical and mental condition and permits him to follow medical recommendations. As a consequence, the vocational counseling psychologist has been given a critical position in the total treatment plan. Gregg (71, p. 6), speaking for medicine, said, "it already depends on the psychologists for help and expects confidently that you will be able to extend and perfect this help."

These developments have resulted in an awareness of the need to set higher standards for hospital counseling psychologists and state rehabilitation counselors, to plan for the training of new counselors, and to establish guidelines for the relatively small group of incumbent vocational counselors who have watched with both satisfaction and apprehension the acceptance of vocational counseling by the medical and ancillary services. One current training program of major importance is that headed by Dr. Robert Waldrop (152, pp. 1-7) in the Veterans' Administration Department of Medicine and Surgery. Another is the expanding program of the U. S. Department of Health, Education, and Welfare, Office of Vocational Rehabilitation, for the training of state vocational rehabilitation counselors.

Furthermore, effective work in assisting a handicapped person to make a good vocational adjustment inevitably brings more referrals from the physician and other rehabilitation workers. The load of clients has not been easy to handle with small and inadequately trained counselor staffs. Past and present counselors have worked hard, but their tools and their ability to use them have not been adequate. Their research and interchange of information and their discussion of problems with each other have indeed been meager.

Increased interest and activity, lack of adequate tools, research, and effective interchange of ideas in rehabilitation vocational counseling are not problems limited to those institutions serving veterans. Private hospitals, institutions for the treatment of special physical conditions, university-

affiliated institutions, and the expanding state programs are all faced with the same problems. Waldrop (157, p. 2) quotes Rusk as having predicted that by 1980 there will be one physically disabled, chronically ill, or person over 65 for every working individual. Even the national administration is becoming concerned over the need for successful planning and placement of disabled persons, not only for humanitarian reasons but in the interests of the national economy, as the proportion of persons in the disabled categories of our population rises steadily. Waldrop (157, p. 2) points to the report of the President's Commission studying health needs of the nation, which emphasized that shortages are serious in the counseling area as well as in the other paramedical areas. He also emphasized the importance of the team concept implied in the meaning of the term *paramedical* (that is, alongside the medical).

All these facts point, of course, to the urgent need for the training and utilization of more counseling psychologists. In turn, it follows that there is a real need to bring together whatever material exists that can be applied to hospital and rehabilitation vocational counseling in order to facilitate the in-service training of present counselors and the training of new counselors. Both Pepinsky (105, p. 4) and Wrenn (172) have pointed out that the various aspects and types of counseling are far from being integrated at this time. This is particularly true in the rehabilitation area. One of the first steps toward meeting the needs of rehabilitation counseling is the integration of the principles and techniques of vocational counseling with the available facts on disability and medical conditions.

DISTINGUISHING FACTORS OF REHABILITATION COUNSELING

Much of the academic training and practicum work of vocational counselors deals with student counseling, career planning, and high school guidance programs. Rehabilita-

tion counseling with adult patients, however, is different from counseling with students. Much has been written about the latter, little about the former. Robinson (109, p. 178) has indicated that there are differences, for example, in resiliency and amount of upset caused by problems, between working with students and working with adults. Adults may have less desire for, and less possibility of, making adjustments to meet new problems. Their patterns of living have become more firmly established. Greater upset may be caused by their problems.

Adult rehabilitation counselees are likely to have more family responsibilities and greater economic problems. As a group they are likely to be drawn from a lower socioeconomic level than are students. More different professional disciplines ordinarily are involved with adult rehabilitation clients than with students or other adults participating in counseling, and more co-ordination of services and team activity is necessary to avoid counselee and counselor confusion. There is greater need for the rehabilitation counselor to be familiar with medical terminology and medical conditions in terms of such things as treatment plans, prognosis, implications for future living, and residual disabilities. The rehabilitation counselor is also likely to be concerned with a greater range of occupational experience and occupational possibilities (including skilled, semiskilled, and unskilled levels) than the student counselor. The rehabilitation counselor will be working also with homebound patients, retired or severely handicapped patients desiring only diversional work, and, sometimes, with terminal patients. He is also likely to be more concerned with such matters as the realities of the present labor market and effective relationships with outside placement and social agencies than is the student counselor. In addition, the student's problems (or those of the physically well adult) and his awareness of them may have been accumulating slowly. In many cases, the injury or illness that now requires readjustment for the rehabilitation

client may have come about suddenly and traumatically. He may require a longer period of time to accept his status and to desire to participate in vocational planning.

The hospital or rehabilitation vocational counselor must consider differences such as these, with the added complications of illness and disability. He is called on for solutions to complicated vocational problems or, at least, for realistic tentative plans, and he must respond to his growing responsibilities. Interest is being focused clearly on his activities.

PURPOSE OF THIS ANALYSIS

In the preceding sections the increasing activity in vocational rehabilitation counseling and the factors that distinguish it from other types of counseling were pointed out. Also touched upon was the current stress on the team approach in rehabilitation. Our primary concern now is to determine how the vocational counselor best fits into the medical team. What are his responsibilities, duties, and procedures? How can he contribute to other services, and what can he get from them that will increase his effectiveness? What differences in approach do different specific disabilities suggest in the counseling process? Despite the present emphasis on vocational counseling in hospital and rehabilitation settings and the fact that counselor training programs are underway, one can search the literature in vain for comprehensive treatments of the vocational counselor's role in the hospital setting.

In this study an effort will be made to bring together in one place many of the facts that rehabilitation counselors should have available for ready reference. At least they should be thinking about these problems. Much research is needed, but first there needs to be a pulling together and a critical examination of available principles and facts derived from the literature and from experience in vocational counseling with the physically handicapped.

To accomplish this we must draw heavily on the work and writings of psychologists in the various divisions of our

science. But numerous excursions into other disciplines, such as medicine, physical medicine, sociology, and education, must also be made, since relatively little has been published by psychologists on research or method specific to hospital vocational counseling. There are books on medical psychology, but their scope has been pretty well limited to the area of clinical psychology. Their application for vocational counseling psychologists confines itself largely to counseling with neuropsychiatric patients. This analysis is oriented toward the problems and procedures of vocational counseling psychology and is not concerned with the methods of clinical psychology in the medical setting, except, of course, for the interrelationships which both services experience as members of the total medical team.

It should be noted that helpful guides and check lists for the use of medical and counseling personnel attached to agencies, institutions, and industry have been developed; for example, those of the U. S. Department of Labor (143, 37 pp.) and the Veterans' Administration (151, p. 2). Often, although these lists appear to have much face validity, they cover physical limitations too generally (often with negative emphasis) and neglect the individuality of the patient and his particular kind and degree of disablement. They might be most useful as selection devices for the industrial placement officer. The vocational counselor who is cognizant of the great individual differences of patients and their medical conditions, even within the same diagnostic category, is perhaps in need of more than generalized systems of matching physical capacities with job requirements. He has to become familiar with general medical conditions and their psychological implications and then know how to obtain and interpret additional specific knowledge of the individual's condition. This entails discussion of knowing what to look for, how to ask about it, and how to fit in effectively with other hospital personnel.

It is not expected that all hospital and rehabilitation counselors will necessarily agree with the particular emphases of this analysis. It is hoped that this bringing together of data from many different sources will encourage more effort to study, discuss, and report the problems inherent in the process of vocational counseling in hospitals and rehabilitation agencies.

S U M M A R Y

Interest and activity in vocational counseling in hospitals and with the disabled is developing rapidly, with more emphasis being placed on the team concept and the total rehabilitation plan. The vocational counseling psychologist has been given a critical position in this plan.

Since the future promises us greater numbers of disabled persons, hospitalized veterans, and older persons, there is an urgent need for more and better trained rehabilitation counselors, and training programs of major importance for new counselors are already underway. Also manifest is the need to set higher standards for these counselors. The rehabilitation counselor needs special training in such areas as knowledge of medical conditions and effective team and agency relationships to be qualified to work with the handicapped adult.

Leading authorities have pointed out that counseling is still evolving and that the various aspects and types of counseling are far from being integrated at present. Most pertinent to the hospital counselor's role is the integration of the principles and techniques of vocational counseling with the available facts on disability and medical conditions. This analysis attempts to study the literature of medicine, psychology, and other related disciplines and to bring together, in one place, many of the facts that hospital and rehabilitation vocational counselors should have available for ready reference. It is not presumed that this study will present final answers; but it is hoped that the following chapters will

provide, in some measure, a comprehensive treatment of the rehabilitation counselor's responsibilities, duties, and procedures.

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¹ The Selected References that follow most of these chapters include only essential studies. The numbered references throughout the text correspond to those listed in the Bibliography at the back of the book.

2

Responsibilities of the Rehabilitation Counselor

RESPONSIBILITY TO THE PATIENT

The vocational counselor in the hospital setting has several responsibilities, to the patient, to the team, the agency, his profession, and to society. Most important, of course, is his responsibility to the patient with whom he is working. He must, however, function within the rules of his agency and under the laws it administers and within the procedures of his local hospital, but his primary concern must always be to help his patient to achieve suitable vocational adjustment. The counselor in a service setting who feels that his first responsibility is to conserve agency funds or to render legal interpretations of eligibility for services is confusing administration with counseling. Certainly the counselor needs to be aware of financial and legal limitations, but he would do well to defer such considerations until his relationship with the patient has developed to the point of exploring ways and means by which selected alternative counseling plans may be implemented. He must not allow administrative red tape to reduce his counseling procedures to mere legal-advisory functions. The counselor can best help the patient achieve good vocational adjustment in society by considering his patient relationship to be professional rather than administrative and by working with the medical team.

Although he must be objective in his evaluations and professional in his use of procedures, the hospital counseling psychologist must also be primarily concerned with the patient's solution of his problems. As Tyler (136, p. 23) points out, the counselor must genuinely feel the understanding and acceptance that he wishes to get across to his counselee. It would seem that the counselor-patient relationship entails responsibilities similar to those of the physician-patient relationship. Perhaps the good counselor does take his problems home with him and finds himself dedicated to his professional relationships in a way which transcends eight-hour-a-day, businesslike processing of counselees.

THE INDIVIDUALITY OF THE PATIENT

In the rehabilitation setting it is particularly easy to neglect the individuality of the patient and, even worse, his desire to be considered as an individual. Sometimes the interesting aspects of a rare physical condition, or even a conflict in test patterns, leads to referring to this or that "case." It is not unusual in a hospital situation to hear professional workers unwittingly refer (sometimes within hearing of the patient) to "the gall bladder in 308." If the counselor wishes the patient to feel understanding and acceptance, he can hardly afford to shirk the responsibility for assuring individual treatment of each person.

Particularly valuable for counselors, trainees, and others in a professional setting is the refreshing emphasis on individual differences given by Williams (164). The following fable by Reavis (107), directed at the consideration of individual differences in curriculum planning, is quoted here because it may help those who like to categorize and push individuals into set molds and procedures to see the error of their ways:

Once upon a time the animals decided they must do something heroic to meet the problems of a "new world," so they organized a school. They adopted an activity curriculum consisting of running, climbing,

swimming, and flying; and to make it easier to administer all the animals took all the subjects.

The duck was excellent in swimming, better in fact than his instructor and made passing grades in flying, but he was very poor in running. Since he was slow in running, he had to stay after school and also drop swimming to practice running. This was kept up until his web feet were badly worn and he was only average in swimming. But average was acceptable in school, so nobody worried about that except the duck.

The rabbit started at the top of the class in running but had a nervous breakdown because of so much make-up work in swimming.

The squirrel was excellent in climbing until he developed frustration in the flying class, where his teacher made him start from the ground up instead of from the tree-top down. He also developed charlie horses from overexertion and then got *C* in climbing and *D* in running.

The eagle was a problem child and was disciplined severely. In the climbing class he beat all the others to the top of the tree but insisted on using his own way to get there.

At the end of the year, an abnormal eel that could swim exceedingly well and also run, climb, and fly a little had the highest average and was valedictorian.

The prairie dogs stayed out of school and fought the tax levy because the administration would not add digging and burrowing to the curriculum. They apprenticed their child to a badger and later joined the groundhogs and gophers to start a successful private school.

Does this fable have a moral?

The rehabilitation counselor, then, must be practical and selective in the applications of his knowledge. His patient will not usually fit the descriptions of a classical textbook study or present a clear-cut problem because, in addition to the usual problems one encounters in most vocational counseling, there are the complications of disablement or disease, and, in counseling sponsored by public agencies, the problems of low economic status and background. The counselor is responsible for assuming enough flexibility in his approach to different patients to assure preservation of their individuality. Attempting to force patients into set molds may leave them with more problems than they had at the outset of the counseling process.

RESPONSIBILITY TO THE AGENCY,
SOCIETY, AND TEAM

Responsibility to agency and to society may perhaps best be thought of in terms of what Sheviakov and Redl (120) have called the "law of marginal antisepsis," that is, the hospital counselor must be concerned with patient problems and desires all the way to a point where the good of the larger group is threatened by patient behavior and demands. Responsibility to others within the agency framework will be discussed further in the chapter on effective interpersonal relationships.

Although the counselor also has a responsibility, because of his designation and the concepts that have developed around his functions, to be well informed about such things as laws, services, benefits, and occupational opportunities, he must guard against becoming simply a person who explains benefits to which patients may be entitled. He is not just an information clerk who works at explaining services available from other agencies. He is shirking his responsibility as a professional counselor if he buries himself in information-clerk duties. On the other hand, the counselor does have the responsibility for using common sense and making simple information available when no other real problems exist. If the patient's only request is for simple information, it may be upsetting and a real disservice to probe for other problems. In this regard it is refreshing to note diagnostic categories in Bordin's (26, pp. 169-184, and 105, pp. 24-25) list which deal with "lack of information" and "no problem."

It is helpful in most cases if the patient understands early in the relationship that the counselor's role is not to supply quick, ready-made solutions for his problems but to help the counselee to reach a better understanding of his problems and to work out his own vocational plan. Robinson (109, p. 151) feels that clients prefer to let their relationship to the counselor grow out of their interaction rather than

have it stated as an initial ultimatum. However it is done, the counselor has the responsibility of playing the role of facilitator in the learning process of counseling. He assists the counselee in arriving at decisions instead of posing as the expert who will solve another's problems.

Responsibility to the team involves working effectively within the total treatment plan evolved through co-operative effort of the team members. This requires making the data of counseling available to the team and being alert to patient reactions to the treatment programs of other team members.

ETHICAL OBLIGATIONS

Wrenn (173, pp. 172-173), writing about counseling college students, points out that although the counselor does not have the same privileged status of the minister, physician, or lawyer from a legal standpoint, he has an ethical obligation of the same order. This would appear to apply also in the hospital situation. Problems of transmitting information of a confidential nature to others do not seem to be difficult within the hospital team since its only reason for existence is to promote the patient's best interests. These considerations do arise, however, in dealing with personnel outside of the hospital. Gluck (68, p. 484) has presented a comprehensive statement of ethical practices for counselors which should be studied by all who are active in hospital vocational counseling. And, as psychologists, we are all responsible for observation of the APA code of ethical practices (3). Confidential information will come into the hands of clerical personnel in the counseling service, and the counselor has a responsibility for teaching them the necessity for safeguarding patient data. Guileless remarks about interesting patients can easily find their way back to patients with devastating results to the counseling process and, sometimes, the patient.

Mention should also be made of the excellent article by Louisell (91) describing the status of the psychologist as an expert witness and giving some possible reasons for this

present status. The appendix to his article gives what appears to be a good example of how a psychologist might do an excellent job of representing himself if called on as a witness. Louisell promises further articles, dealing, for example, with privileged information, which should prove to be valuable reading for the hospital counselor.

SUMMARY

It has been stressed that although the hospital or rehabilitation counselor has several responsibilities, his responsibility to the patient is most important. He also needs to give careful attention to the individuality of patients and to avoid any attempt to force patients into set molds, a practice which may leave patients with more problems than they had initially.

The idea is advanced that the vocational counselor's responsibility to agency and society may perhaps best be thought of in terms of the "law of marginal antisepsis." Responsibility to the team requires co-operative and effective work by the counselor within the framework of the total treatment plan.

The hospital vocational counselor has ethical obligations of the same order as the minister, physician, or lawyer. References are made to accepted codes of ethical practice for counselors and psychologists, and these should be studied carefully by vocational counselors in hospital and rehabilitation settings.

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3

Effective Interpersonal Relationships

EARNING ACCEPTANCE BY THE TEAM

The hospital vocational counselor must earn acceptance by the other members of the rehabilitation team. He must establish status with them and find the most effective level of operation within the total hospital framework. He must know where and how to get useful counseling information, how to evaluate it, and how he can contribute effectively to the team by providing data he gathers in the counseling process. In other words, the counseling psychologist has to give serious consideration to ways in which effective interpersonal relationships can be established. Isolated on his own service, he can do little more than hope for successful outcomes in vocational planning with his patients. He needs to become an integral part of the dynamic interplay of forces known as the team approach in rehabilitation. He needs to think carefully about how he can sell his service and himself in order to open more data-gathering and action channels that will enable him to do the best possible counseling job with his patients.

The counseling psychologist must learn quickly that he cannot expect just to receive information. He will be expected to contribute from his counseling data, to give interpretations, and to have opinions about his counselees. Gregg (71, p. 7) has said, from the viewpoint of medicine, that "in interprofessional relationships it is manifestly more blessed to be accused of giving than it is to prepare oneself

to receive what the other profession may offer." In the course of vocational planning, much useful information is acquired which is often necessary for the rest of the medical team to know if the patient is to adjust after discharge and be able to remain out of the hospital.

THE HOSPITAL COUNSELOR'S ROLE IN THE TEAM

The hospital counselor must realize that his proper role in the team is that of a vocational counseling psychologist. He should feel he is an equal member and an important contributor to the team, but he must carefully respect the duties of other team members, such as the ward physician, psychiatrist, physiatrist, social worker, and occupational therapist, and not fall into the error of assuming the duties of other disciplines. Since he learns a good deal about the other professional fields, it may at times be tempting to act as though he knows the answers in these areas. The experienced counselor who is secure in his own specialty, however, will know that his knowledge of allied professions, although necessary, is superficial. He will feel that he has more challenging problems in his own area of responsibility than he can handle as well as he would like. He will, for example, be happy to leave medical problems to the physician and deep therapy to the psychiatrist and the qualified clinical psychologist. Whitehouse (162, pp. 50, 51), in an excellent discussion of teamwork in the professions, makes the following pertinent statements:

Superficial knowledge of another profession gives no license to practice it. Co-operation does not mean that one profession helps another by doing some of its job when considered advisable or necessary . . . To be professionally mature is to understand that claim to knowledge of a related field will always be presumptuous for any except those who have *lived* in it, worried in it, made difficult decisions, seen their results, and gained knowledge with depth.

The counselor will do well to consider carefully and to respect the judgments that derive from the extensive education, training, and experience of his fellow team members.

The vocational counselor will also want his counselee to understand that he is not a source of medical information but is primarily concerned with helping the patient to work out a vocational plan within the framework of the total medical-team approach.

The counseling psychologist working in a medical setting should not feel apologetic or insecure when presenting interview, psychometric, personality-evaluation data, or other counseling material or opinions with their vocational implications to other staff members evaluating the patient. Although he should not pose as an expert outside of his field, he should certainly be an authority within his own specialty. When he knows he has sound data to support a conclusion he should not back down in the face of critical comments by someone of prestige in another profession. The vocational psychologist has the best methods for measuring such factors as vocational interests, a level of skill, or an aptitude, and he should demonstrate appropriate faith in his data and his tools if he is to hope for meaningful professional status with the other staff members.

TEAMWORK VERSUS FOLLOWING-THE-LEADER

Effective interpersonal relationships lead to teamwork, which, however, should be recognized clearly as *not* being synonymous with following the leader. In the democratic atmosphere of a well-led case staffing or conference the counseling psychologist will be expected to express independent opinions based on his particular set of data. Too often staff members simply mirror the opinions of the leader or consultant, rephrasing the same ideas in the vocabulary peculiar to the profession represented.

Successful rehabilitation depends upon the co-operative

teamwork of many individual disciplines. But the vocational counseling psychologist, whether or not he desires it, will often find that the success of the total team effort will depend, much of the time, upon the end product of his counseling activities. The counselor depends upon all the other team members and could not begin to do the job alone; but the resolution of vocational, economic and social problems, which permits adherence to such things as work tolerances, prescriptions, and maintenance of dietary schedules, will depend a good deal upon the effectiveness of the vocational planning, the placement efforts made, and the extent to which the patient has wholeheartedly accepted the recommendations of the team effort. It does not help much in the final analysis to stabilize a diabetic, only to have him fall back into the unstable work pattern that aggravated his condition. The counselor must constantly remind himself that the team has given him this responsibility and that he and the patient cannot achieve total adjustment without the combined efforts of the whole staff.

INTERPERSONAL RELATIONSHIPS IN THE HOSPITAL

To work effectively the counseling psychologist must be in constant touch with many disciplines. To indicate the size of his task some representatives of professions within the hospital with whom he should work closely are the ward physician, the physiatrist, the social worker, the physical therapist, the occupational therapist, the psychiatrist, the speech therapist, the manual arts therapist, the corrective therapist, the clinical psychologist, the educational therapist, and the nurse. On a more general level he will also be working with the manager, the director of professional services, the chiefs of medical, surgical, neuropsychiatric, and tuberculosis services, with consultants in his own field, and with his fellow counselors. There will also be numerous occasions, at the patient level, where close work with the per-

sonnel officer, the contact man or information representative, the special services officer, the hospital chaplain, the librarian, the chairman of the local civil service board of examiners, and the service organization representative is desirable. It seems obvious, then, that to function effectively within his own hospital the counseling psychologist needs to be well-known, well-liked, well-informed, and a bit of a salesman in addition to being competent professionally. Of course, this is equally true of each member of the team if *all* are to work together effectively as a team.

INTERPERSONAL RELATIONSHIPS OUTSIDE THE HOSPITAL

Outside of the hospital the vocational counselor must be even more of a salesman and diplomat. Not only must he be respected professionally; he must be able to motivate effort in the behalf of patients and to present data in a fashion that will be useful to the agency or person from whom co-operation is being sought. This requires knowledge of agency operation and some familiarity with industrial personnel policies. Even with this knowledge, referrals to others are unlikely to bear the best fruit unless individuals have been visited regularly and are personally known by the counselor. Wherever possible, the counselor should arrange to have industry and agency representatives learn at first-hand the hospital method of operation, the importance of the selective placement of patients, and the kinds of information useful in patient placement and follow-up that are available from the hospital team. Again, to indicate the magnitude of the counseling psychologist's task, he will probably be active in meetings, consultations, and orientation with some of the following outside representatives: state employment service workers, state rehabilitation division counselors, private employers, representatives of federal agencies, state, county, and city civil service representatives, university, and school representatives, union executives, personnel of

all

other agencies working with the disabled, representatives of sheltered workshops, AA members, and personnel of other hospitals. In addition, if he is to keep abreast of his field of work, he must maintain active channels to professional personnel in nearby universities and colleges. Gleason's (67, p. 35) remarks in this connection are well worth the serious consideration of counselors:

the best vocational counselors are free with their telephones. They drop notes into the mails, asking for information and advice. They have contacts among psychiatrists and other medical specialists, fellow psychologists, social workers, personnel people in commerce and industry, educators, rehabilitation specialists, union officials and employers. They are not inhibited by timidity or by professional jealousy. They do not rationalize a fear of exposing ignorance to people in other professions, by hiding behind the fiction that consultation is too time-consuming to be worthwhile; or a fear of summary treatment from other persons of consequence such as employers and labor leaders, by the conceit that their judgments are not professional.

ESTABLISHING AND MAINTAINING EFFECTIVE INTERPERSONAL RELATIONSHIPS

Perhaps most important in the maintenance of good interpersonal relationships are professional competence and real acceptance of the fact that each discipline or representative is peculiarly qualified to add needed information and assistance in rehabilitating a whole person. When the counselor has learned that the other person's area of specialty has contributions to make that are every bit as important as those of counseling psychology, he will already have made a good beginning in establishing effective interpersonal relationships. Competence, humility in the face of the complexity of human adjustment problems, and a conscious effort to avoid "playing God" will go a long way toward establishing good relationships.

It has been stressed that counselors should have opinions and should avoid simple following of the leader. Discretion has to be used, however, with great skill. Little is achieved

by arguing minor technical points in the data when larger issues are at stake. There are proper and improper ways of presenting conflicting data, and preferred times for doing it, so that the prestige of another team member or service is not threatened. The team attitude is a co-operative one, and suggested courses of action are the products of group thinking. There should never be a contest to see which service can shine the brightest. Learning to know and understand the underlying philosophies of the various services will help the counselor a good deal in this respect. //

Currently we think of counseling as a learning process. It might help to think of interprofessional relationships in the same manner. All are learning as the plan for the patient develops. No one has pat solutions, since none has encountered this particular problem before. All are co-operating and avoiding as much trial and error as possible by utilizing a combination of the past experiences of each specialty.

The size of the task of establishing good relationships has been emphasized not to demonstrate the importance of the counselor but to point up the need for effective interpersonal relationships and for selecting counseling psychology trainees who have personal qualifications beyond the area of academic competence.

S U M M A R Y

To earn acceptance by the rehabilitation team and to establish status with the team members the vocational counselor must give attention to ways in which effective interpersonal relationships can be established. He needs to sell himself and his service. He must also realize that he cannot expect just to receive information; he needs to contribute from his counseling data.

It seems essential that although the counselor should feel he is an important contributor to the team and an equal member of it, he should remember that his role is that of a vocational counseling psychologist; he should not invade

other areas of responsibility. Within his specialty the psychologist should feel that he is the team specialist, and he should demonstrate faith in his data and tools.

To indicate the size of the vocational counselor's task in establishing these relationships many examples of persons with whom he should work closely within the hospital or agency, outside the agency, and in his own profession have been cited. It has been emphasized that he needs to be well-liked, well-known, well-informed, and a bit of a salesman as well as professionally competent. In establishing and maintaining effective interpersonal relationships, it has been stressed that professional competence, acceptance of the ability of other disciplines to contribute needed information, and the use of discretion in the face of conflicting team opinions are important.

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PART TWO

Relationships with Other Services

4

Relationships with the Clinical Psychology Service

In dealing with the relationships of the rehabilitation counselor with other services, it is felt that attention should be given first to relationships with the clinical psychology service. There are two reasons for this: (1) the recent interest and activity in defining the areas and methods of practice of clinical and vocational counseling psychology, and (2) the author's conviction that each of the two areas, working co-operatively, has distinct contributions to make to the rehabilitation effort that might be jeopardized by a merger of clinical and vocational counseling psychology. Articles such as those by Hahn (72, pp. 279-282) and Super (131, pp. 3-9) illustrate the interest in clarifying and justifying the areas and methods of practice in these two specialties. The vocational counseling psychologist in the service setting will need to keep abreast of developments and to have convictions if he is to understand his particular role in the rehabilitation effort and to be aware of the distinct contributions he can make.

NEED FOR CO-OPERATIVE RELATIONSHIPS

There is much occasion in the hospital setting for the sharing of data, opinions, clinical hunches, research ideas and results, and perhaps training facilities by the vocational counseling psychologist and the clinical psychologist. If both

services happen to be working on the same patient team, it would seem uneconomical and burdensome to the patient to duplicate personality testing, providing there is close enough liaison and agreement on the meanings and usefulness of the instruments and techniques used. It is to be hoped that in most hospitals the efforts of the two services are co-operatively productive. In particular quarters, however, differences in background, theoretical orientation, and training create friction. One person might place great stock in a test, such as the Rorschach or the Szondi, in which the other professional person might find it difficult to place much credence. His own review of reports on the test in question might well lead him to believe that it should be interpreted with caution, if it is used at all. This should not often be the case, however, since both services usually are well grounded in testing, evaluative, and interpretive techniques, and hospitals tend to draw personnel of the same theoretical leanings to their staffs.

Ordinarily relationships should be most co-operative. One service might even do a good deal of the testing for the other if this is the most convenient arrangement. If the clinical psychologist is attempting to formulate opinions about a patient with whom the vocational counselor is working, the vocational counselor should supply him with pertinent interview and ability data. On the other hand, if the clinical psychologist has previously worked with the patient or is currently doing so, the vocational counselor will certainly wish to consider his opinions on the patient in making his total evaluation.

If only one of the services happens to be active with the patient during the current hospitalization, it seems obvious that referral for the services of the other professional person, if warranted, should be borne in mind. The vocational counselor will probably realize his limitations in the areas of neuropsychiatric diagnostics and psychotherapy, and the clinical psychologist will probably realize his relative un-

familiarity with general medical and surgical patients, vocational counseling interviewing and testing techniques, and occupational and labor market information.

If the vocational counselor in his planning with the patient encounters personality data which seem particularly pertinent to vocational success, he will probably wish to get the additional independent interpretation of the clinical psychologist. He may wish to heed suggestions for further evaluation or refer the patient for concurrent work with the clinical psychologist. On the other hand, if the clinical psychologist, with the psychiatrist, finds that lack of vocational planning culminating in adjustment after actual job placement is a major or contributing cause of the current personality problems of the patient, referral to the vocational counseling psychologist with his experience, interests, and valuable contacts in the job-planning and placement area would seem to be entirely logical. The important point is that both services have a good deal to contribute to the successful functioning of each other. In most hospitals this is realized; in some there is still relative isolation and even professional jealousy.

At this point, mention should be made of the fact that the professional people in both clinical and vocational counseling psychology are psychologists first and then specialists in a particular subdivision. Neither should look down on the other. Remarks such as "He's one of those clinical people" or "That vocational placement man" do nothing but hamper co-operative effort and leave an impression of immaturity in the minds of other professional people with whom both services work. Both services are comprised of basic psychologists who have different interests and perhaps different leanings but who can contribute to each other and who are interested in the science of human behavior as it applies to their respective tasks and functions. The physician is interested in general health and physical well-being. If he is a tuberculosis specialist, he does not look on the surgeon as a

rival but as one who, with his own interests and techniques, can contribute to the solution of the problem. The surgeon, on the other hand, looks to the medical specialist for data and opinions so that he can know best how to direct his efforts in treatment and research.

DISTINCT AREAS OF CONTRIBUTION

It should be obvious by now that the author feels strongly that although clinical and vocational counseling psychologists must function in a workable and co-operative arrangement, they represent distinct services. Neither is a second-rate psychologist in reference to the other; each supplements the other but has a distinct area of contribution to the hospital and the total team effort to rehabilitate patients.

In practice the clinical psychologist has worked mainly with the psychiatric team in a total effort to understand and treat the neuropsychiatric patient. He has been concerned with contributing to the data available for best diagnosis and has contributed to psychotherapy in the hospital, particularly in hospitals understaffed with psychiatrists. He has been active in research, more so than the hospital vocational counseling psychologist, but his interests have confined him largely to the area of research with neuropsychiatric patients. He has become a specialist in diagnostic testing, primarily with neuropsychiatric patients or neuropsychiatric techniques. He has not concerned himself much with aptitudes, general medical and surgical disabilities (except where psychosomatic factors loom large, as, for example, with gastrointestinal patients), the realities of the labor market, and interpersonal relationships with other medical and placement people outside of the psychiatric team.

On the other hand, the vocational counseling psychologist stresses the practical aspects of measuring intelligence, aptitudes, and vocational interests, and the procedures and relationships necessary to achieving good job placement. He has

not learned much about the use of projective techniques and may not have learned as much as he should about profile configurations on the Minnesota Multiphasic Personality Inventory. Perhaps he knows psychoanalytic theory more as an historical part of the development of psychology than as a possible technique to be explored. He has emphasized the disability problems of patients in general rather than specializing almost entirely with the neuropsychiatric patient. He is likely to be experienced in dealing with less extreme personality deviations, where the emotional adjustment factor is only a part of the problem of successful rehabilitation.

CONSIDERATION OF A MERGER

Source of the Idea

It appears likely that in the future there will be increasing consideration given to the merging of clinical and vocational counseling psychology into one hospital psychology service. Superficially, this appears to be desirable, since each service is comprised of professional people who are basically psychologists, oriented in general psychology and skilled in the application of the scientific method to whatever behavior problems may arise. Those most vocal in favor of such a move seem to be the clinical psychologists, perhaps because of their strength in numbers in the Ph. D. ranks, perhaps because of honest conviction that a new arrangement would be more efficient administratively, or perhaps out of desire to break away from the close supervision by one medical specialty, the psychiatrists, to supervision by the general medical profession. The vocational counseling psychologists have not particularly favored such a merger, perhaps because of their relatively recent move toward training at the Ph. D. level for hospital vocational counselors, perhaps because they do not see a merger as a real contribution to the rehabilitation effort, or perhaps because they do not wish to de-emphasize

a difference between the two specialties. The vocational counselor in the hospital setting is a very busy individual and is not likely to be seeking additional duties or training.

Differences in Dedication

It would appear that professional people specialize within their science because of specific interests and a sense of dedication to certain procedures in which they wish to participate to reach particular goals. The clinical psychologist has demonstrated interest and dedication to diagnosis, therapy, and research in the area of psychiatric disability, whereas the vocational counseling psychologist has evidenced interest and dedication in the areas of general vocational adjustment, with its attendant aptitudes, interests, personality factors, job information, counseling, and placement procedures, and with the research problems that deal with the proper selection and placement of patients with disabilities. One likes also to believe that the psychologists concerned had some insight into the possible effectiveness of their own personality structures and training in selecting their specialty. It seems possible that some vocational counselors would make poor clinicians and that some clinical psychologists would be quite inadequate assistants to the patient in his vocational planning.

Differences in Vocational Interests

Kriedt's (89, pp. 482-488) study of the vocational interests of psychologists led him to the development of keys for psychologists, and for clinical, experimental, guidance, and industrial specialties with different interest patterns. This would tend to bear out the opinion being expressed here that the two specialties under consideration are likely to have attracted psychologists with different interests. If there were no real differences in interests, Kriedt would not have found it possible to develop separate keys. It is interesting to note that the correlation between scores of individuals on pairs of keys was found to be only .28 plus-minus .09 for the

clinical key vs. the guidance key. Clinical and industrial correlated $-.13$ plus-minus $.09$, and guidance and industrial correlated $.54$ plus-minus $.07$. The fact that the study was done in 1949 suggests why he used the term *guidance*. At that time, Veterans' Administration guidance centers were widespread, and the term *counseling* was just beginning to supplant the term *guidance*.

Training Clinical-Counseling Psychologists

To train a new brand of synthetic clinical-counseling psychologist seems hardly feasible at a time when it is difficult to include in the respective curricula all the desirable theories, facts, and techniques considered essential for either specialty. There are feelings that both specialists could be trained in basic scientific technique, and this, of course, is desirable; but such training alone might well lead to less qualified persons in both specialties. Training psychologists to be good researchers is necessary, but to stress this at the expense of knowledge of workable techniques would seem to be a mistake. As much as theory and research are needed, in the service setting, the outcome of any research will have to depend upon the contribution to patient rehabilitation that is being made concurrently. We are not hired primarily as developers of our science, even though this is important, but as specialists with a contribution to make toward improved patient care and total posthospital patient planning.

Age and Experience of the Two Areas

A note should also be injected on the "newness" of the vocational counseling psychology program relative to the development of the clinical psychology program in hospitals. Although the emphasis on additional academic training for vocational counseling psychologists working in hospitals is only a little more than two years old, whereas the clinical program is more than ten, vocational counselors and other rehabilitation workers were very active in the problems of

vocational planning with patients as early as 1944 and 1945 in hospital settings in the Veterans' Administration. And much work had been done in the general field of vocational planning long before that time. Vocational counseling and rehabilitation work are not new programs. Like all specialties, they need constant development and improvement and can learn much from other specialties. Vocational counseling psychology, however, is not lacking in experience; it is quite able to stand on its own feet and can point to a record of achievement in patient rehabilitation.

The Zeitgeist

There is some feeling that merger rather than co-operation between clinical and vocational counseling psychology is a kind of inevitable product of the times, a sort of by-product of the *Zeitgeist*. This is difficult to understand when there are two well-defined, necessary, and productive specialties, capable of co-operative effort, each with members supposedly dedicated to the work they are doing. There seems to be no thought of such a merger, for example, between the medical internist and the orthopedic specialist—and the analogy does not seem too remote.

Significant Articles

4 The article by Super (131, pp. 3–9) on the transition from vocational guidance to counseling gives an interesting account of the developing recognition of counseling psychology, the development of a psychological job title, and the current interest in a possible merger of counseling psychology and clinical psychology. It is difficult, however, to agree completely with some of the statements he makes. Although it is true that counseling psychology emerged more clearly as a field in its own right in 1951, in terms of such things as job titles and recognition that more attention needs to be given to training and developing additional numbers of counselors, it seems hardly appropriate to allude to counseling psychol-

ogy as a "debatable field of psychology" prior to 1951. It also seems somewhat misleading to state, in 1955, that "now rehabilitation has begun to make demands on vocational counseling which are appropriate to counseling psychology and which command its attention." It is true that rehabilitation is making increasing demands on vocational counseling, and the vocational counselor is being given more responsibility in the team approach to patient treatment and planning. These demands and this responsibility, however, are at least partly the result of the work of vocational counselors who started to meet the demands of rehabilitation in Veterans' Administration, state, and service programs as long as twenty years ago.

It is also difficult to understand how Super, who has demonstrated his dedication to, and leadership in, vocational counseling psychology, can rather placidly state that "perhaps in due course the two fields will merge, in a more broadly trained and oriented field." His article ends with the statement:

Perhaps the end result will be emergence of a field of applied individual psychology, or consulting psychology, in which psychologists will be prepared to function as consultants to people in varying situations and with varying types of adjustment problems. Perhaps, on the other hand, true differences in the several fields will emerge more clearly, and both applied psychologists and the general public will develop a new recognition of and respect for the various applied specialties.

These statements would seem to imply a relative ease in combining the training programs for the two areas. It is also surprising to note that Super did not cite the evidence of Kriedt relative to the interests of psychologists.

Another contribution to this discussion has been made by Hahn (72, pp. 279-282),¹ who develops for us "a relatively unique pattern of function for the counseling psychologist which, it is hoped, will show clearly that we are a legitimate and discrete group of practitioners. The pattern does not ap-

¹ The subject also is discussed in Hahn and MacLean (72a).

pear to be duplicated in large part by our colleagues in related fields." Since it is felt that Hahn's contribution is important reading for all vocational counseling psychologists, the summary of the relatively unique pattern of function for the counseling psychologist is quoted from his article as follows:

First, the major concern of the counseling psychologist is with *clients*, not *patients*, from the mass of people who can support themselves and live with reasonable adjustment in our society.

Second, our employment is in situations which do not place us professionally under the direction or supervision of related disciplines either as a matter of policy, law, or political or economic conditions.

Third, our tools and techniques of practice are based in general more on normative approaches than are those of related disciplines.

Fourth, we tend to emphasize learning theory at the cognitive, intellectual, and rational levels although not omitting orientation to the content of psychodynamics. We help *clients* to change attitudes and value systems, but we rarely attempt the major restructuring or rebuilding of a personality.

Fifth, we deal usually with anxiety states at the frustrating, interfering levels, not when disability or disintegration is indicated.

Sixth, and our most nearly unique single function, we are the most skilled professional workers in the assessment and appraisal of human traits for educational-vocational-social living: the casting of a psychological balance sheet to aid our *clients* to contribute to, and to take the most from, living in our society.

Seventh, we are obligated to follow our *clients* beyond the office door. Until there is *client*-accepted planning for such future action as formal education or training, vocational exploration, and social direction, the counseling process is not complete.

Eighth, and last, we stress positive psychological strengths and their personal and social use as opposed to a process of diagnosing and remedying psychopathies.

For the hospital counseling psychologist, it should be pointed out that Hahn's distinction between patients and clients appears, throughout his article, to be a distinction between psychiatric patients and other clients. It does not appear that he wishes to distinguish general medical and surgical patients from clients. It should also be noted that in

reference to his distinction on employment situations he points out that in the Veterans' Administration "the Chief of Counseling Psychology in many hospitals reports directly to the Chief of Professional Services and not through a psychiatrist."

It is unfortunate that the work of Thorndike (134, pp. 205-207) on the structure of preferences for psychological activities among psychologists does not take Kriedt's items into account and does not include enough items pertaining to counseling or to clinical psychology. Had the 119 items in the original activity preference form been retained it might have been a more useful device for exploring the differences under discussion in this chapter. The fifty-item form presented by Thorndike appears to have a preponderance of items describing clinical activities, with few items related to the activities of the counseling psychologist.

Administrative Economy

The possibility, of course, must be considered in hospital settings that there might be economy in administrative costs to have a single psychology service, headed by a psychologist who has demonstrated competence in administration and who will provide general administration for the two specialties. This is a matter of administration, however, and not a matter of turning out "clinical-vocational psychologists."

ILLUSTRATIVE CASE HISTORY

The case notes which follow indicate how a vocational counselor, whose orientation and training apparently were largely in clinical psychology and who worked in a setting where distinctions between clinical and vocational counseling psychologists did not appear, to this writer at least, to be clear, reported counseling progress to his ward team. The left-hand column gives notes on the counselor's presentation; the right-hand column contains the author's comments and should indicate some of the questions that would arise for

the psychologist whose orientation is in the area of vocational counseling. The case history on which these notes are based was presented at a training conference to illustrate the vocational counselor's role in the ward team.

Notes on Counseling Report

Single, white, twenty-one-year-old, psychiatric ward patient. Seen to evaluate feasibility of instituting an occupational plan to contribute to rehabilitation.

Initial interview: submissive, no strong subjective feelings. Subsequent interviews: increased animation and interest; verbalized more readily; appeared to gain in security.

Increased interest and gain in security attributed to success and satisfaction obtained from past and present work habits which were providing motivation to return to community, start a training program, and actualize occupational potentialities.

High school graduate. Liked physics, and chemistry. Spare-time work as tile setter's helper with father. Short-time jobs such as newsboy, grocery boy, soda dispenser, service-station attendant, and camp counselor. Father died one year prior to completion of high school. Post high school jobs: furnace company service salesman; quit job after three months—disliked sales work. Worked six months as a machinist's helper and inspector for camera corporation. Helped some on setting up machine tools. Terminated job for formal toolmaker apprenticeship. Inducted into Army after one year of

Comments

Diagnosis? Response to treatment? Patient's preparation for counseling?

Beyond stating that patient appeared to gain in security, there seems little basis for the remaining statements aside from the counselor's hope.

What does the patient's high school record show? With a relatively long-term patient there may be ample time to check school progress with the school or the local university having high school records. Are data on tests taken in high school also available?

How much did he learn and retain? Mechanical comprehension and/or trade test in order? Employer reports of progress on the job?

Since hospitalization in

Notes on Counseling Report

apprenticeship. After a few weeks in the Army, became a hospital patient until discharge from service after about one year.

Patient has engaged in types of educational and manual arts therapy having a distinct occupational orientation. Typing, mechanical drawing, and machine-shop practice were included. Therapists report co-operative attitude, consistent attendance, interest, perseverance, and progress. Statement made that activities and work habits have become so much a part of the patient that he states he would feel lost without them. He is stated to look forward to resuming his formal apprenticeship for the objective of tool-maker.

The feasibility of a comprehensive occupational plan leading to toolmaking is reported to be augmented by the following psychological test results:

Otis SA Higher IQ of 113—high average intelligence. Kuder measured interests predominate in the mechanical (80th percentile) and science (83d percentile) areas—high average. Purdue Pegboard—high average manual and fine assembly work dexterities.

Minnesota Paper Form Board—average aptitude (30th percentile), on norms for high school graduates, for visualizing spatial relations. Statement is made that this aptitude is usually associated with success in complex mechanical jobs. Statement is also made that potential mechanical ability of the patient is probably greater than

Comments

service came so quickly, was he also fairly maladjusted prior to service? During the apprenticeship period?

Don't most educational and manual arts therapy activities have a distinct occupational orientation?

Why the range of activity from typing to machine-shop practice at this point? Was this patient's choice or diversional activity? Was it part of a counseling plan?

Will he feel lost without typing too? Might the patient mean he will feel lost without some activity and the therapists on whom he depends?

High-level objective arrived at rather quickly? Is the goal to arrive at the best occupational plan, or did manual arts therapy assignments stem from preservice work during a period of probable maladjustment, and is the counselor now seeking best evidence for sending patient back to the same situation? This is not to suggest that changing occupations is a goal of counseling. Broader exploration might be in order with this patient.

True, but does the patient have much of the aptitude?

Greater potential ability to compete with slow and methodical high school gradu-

Notes on Counseling Report**Comments**

the score indicates because the patient prefers to work slowly and methodically on a speed test.

ates or with men in mechanical jobs who work slowly?

Patient's responses on the Bell Adjustment Inventory indicate he considers adjustment good in the occupational area, and average for health, home, and emotional areas. He recognizes and admits retiring social behavior. Statements made re. personality as reflected by the Szondi Test: simple personality structure; attachment to mother figure not surrendered; repression maintains narcissistic integrity of the ego.

Can results from the Szondi really reflect all this? Rather positive statements based on a test that reviewers feel must be used with caution, if at all?

Patient is willing to accept environmental limitations and to deny open narcissism. Interests himself in materialistic aspects of life and tries to be regular like others.

Occupational significance re. toolmakers specifically?

Characteristics conducive to social learning and self-control should be encouraged. They might be channeled in the occupational training program.

Most occupational training programs?

Patient is summarized as having considerable assets for utilization in a training program for toolmaker: high average intelligence, ability for junior college work, interests in the mechanical and science areas, manipulative dexterity, adequate aptitude for mechanical work, apprentice experience, excellent reports of therapists, and adequate personal characteristics.

Also some questionable assets?

Do we know this?

How much did he learn and retain? Skilled, or just a co-operative patient in manual arts therapy?

It was felt desirable as a result of the counseling procedure to start on-the-job training when the patient was

Is this really a result of the counseling procedure, or did counseling simply follow

Notes on Counseling Report

ready for trial visit. It was stated that the state division of vocational rehabilitation would help find a training facility. If no facility were available, institutional training might be financed by them.

Comments

along? What planning and exploring did patient and counselor do? What were the results of therapy with the patient? How are plans or circumstances different now from what they were just prior to the patient's breakdown?

Are the training plans too general to be meaningful? Choice of on-the-job or institutional training usually depends upon such things as the apprenticeship standards, the union, accreditation for institutional courses, and proposed locality of work. Both kinds of training are not equally acceptable for any locality and any patient. Were these factors explored with the patient? How much use was made of occupational information?

S U M M A R Y

It has been stressed that co-operation between the clinical psychologist and the vocational counseling psychologist is both necessary and fruitful. Each has a definite area of contribution to the other and to the total hospital or rehabilitation program. The increasing amount of consideration that is being given to a possible merger of clinical psychology with counseling psychology has been discussed, and attention has been called to possible differences in the dedications of the individuals involved, to the evidence of differences in vocational interests in Kriedt's work, and to the possible difficulties involved in planning a training program that would include the necessary preparation in both specialties.

Articles by Super and Hahn reflect thinking on the relationships between clinical and counseling psychology. Hahn's summary of the relatively unique pattern of function for the counseling psychologist has been quoted in the hope that it will be carefully studied by vocational counseling psychologists.

A case history was given to indicate how the approach to job planning used by a vocational counselor with primary orientation in clinical psychology differs from that used by a counselor who is vocationally oriented.

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5

Relationships with Other Professional Services

As was indicated in the section on interpersonal relationships, the counselor cannot hope to operate independently in his counseling relationship with patients. The amount of his contribution to the rehabilitation team effort and the effectiveness of the vocational planning after the patient has left the hospital will depend a great deal upon how much he has been able to utilize and contribute to other professional services which have been active in the total treatment effort. Although some professional services may appear to be emphasized more than others in this analysis, the actual utilization of such services by the counselor in individual cases will depend, of course, upon the particular patient needs. In many cases, all services will enter to some extent into the treatment plan. There also are undoubtedly more ways in which to participate with other professional services than the few examples that are mentioned in the following sections.

THE PHYSICAL MEDICINE AND REHABILITATION SERVICE

The vocational counselor can contribute significantly to the total rehabilitation plan by actively working with personnel in the physical medicine and rehabilitation service. If he has built up the proper professional relationships, so that his findings and opinions are desired, he will be active in

many case staffings of patient problems. These case discussions will ordinarily take place in hospital rehabilitation board meetings or similar group meetings of those representatives of the professional services who are active in planning with the particular patient under discussion. Such hospital meetings will ordinarily be co-ordinated and led by the chief of the physical medicine and rehabilitation service. The purpose of these meetings will be the co-ordination of the efforts of all workers toward the recovery of the patient so that he will be able to leave the hospital. A further objective is to achieve careful planning for vocational adjustment after hospital discharge so that the patient's hospital treatment will have been worthwhile and he will not be returning again with exacerbation of his medical condition. Mention will be made in the section on special services of the latest developments in veterans' hospitals in planning for postdischarge adjustment of the patient. The hospital vocational counselor, in addition to contributing to these case staffings, will probably also have occasion to recommend the staffing of patients for whom he feels that better co-ordination of all services might be desirable.

In these rehabilitation meetings the vocational counselor may be called on to report on the patient's educational and occupational background, to develop and give his prognosis for an occupational plan for a patient, to describe the duties and physical and environmental factors involved in particular jobs, to describe necessary training and facilities in the area, to develop a plan for placing a patient on a job, to give an opinion on whether or not a patient can be placed on any job, to report on measured or estimated patient intelligence, special abilities, and vocational interests, to comment on patient motivation to work or to get well, to report on pre- and postinjury mental status of the patient, and to generally assume responsibility for the vocational planning aspects of the rehabilitation process. He will want also to take advantage of the group meeting to request information on physical

status and prognosis, length of stay that is contemplated for the patient, social background, and progress in specific activities of other services.

In his vocational planning with patients, the counselor is in an especially good position to suggest referrals to sections or agencies providing educational therapy, occupational therapy, and manual arts therapy. Participation by the counselee in the activities of these sections greatly increases the probability of success in the counseling effort, and also gives the hospital patient the feeling that occupational planning has reality even while he is still hospitalized.

The counselor can obtain much useful specific information from physical medicine and rehabilitation facilities (physical therapy, occupational therapy, educational therapy, corrective therapy, and manual arts therapy). He can, for example, find out how the patient appears to be getting along with other patients and with the therapists; how much motivation he seems to have to get well; how much energy he puts into the completion of various projects and courses; what kinds of materials and skills he likes to work with and how well he does with them. The counselor can and should also contribute similar facts on which he has data from the counseling relationship. Perhaps his most valuable contribution to these services will be the assistance he is able to give in helping to plan the direction of activity in such a way that it will have lasting meaningfulness in a vocational or total adjustment sense.

Educational Therapy

A patient with a relatively long hospital stay ahead of him may be started out in course work in the planned vocational field. This will allow him to get the advanced start that he, as a disabled person, may well need when he leaves the hospital, since other adjustments to his disability are apt to demand a good deal of his time when he starts on a new job or begins a more formalized training situation.

A patient may be encouraged to get a taste of various kinds of course work as a prevocational step before making final job or training commitments. He also may be asked to look over some of the educational therapy course materials, books, and manuals as a supplement to occupational information available in the vocational counseling service.

A patient who wants to learn a skill, like drafting, but who feels his specific disability may not allow it (for example, a crippling hand condition), may actually try the activities involved in the more sheltered educational therapy setting and satisfy himself and the counselor that he can or cannot physically participate in learning the particular skill.

Educational therapy may be used to give the patient the opportunity in an individualized teaching situation to develop confidence that he can master certain skills and certain subject matter. Often a patient has the interests, intelligence, and potentialities for a higher level skill but has had experience only at the unskilled or semiskilled level and, consequently, feels limited to that area of activity.

In some cases, the actual taking of courses will emphasize to a patient, who will not or cannot accept his limited abilities for an occupation, the fact that he will have difficulties in the field he desires. This is often a much more effective technique than trying to discourage the patient directly and seems to be less traumatic to the patient. He has time to think of reasons for gracefully changing his desires, and *he* makes the decision that this is not the field for him. In other cases, where friends or relatives are overly influential and have definite plans for the patient's vocation, this kind of vocational tryout may give the patient enough actual experience on which to start making his own decisions.

There may be therapeutic value in keeping the patient actively engaged in worthwhile activity during a long hospital stay; it helps to divert some of his thoughts from himself and his symptoms. If this can be tied into the vocational plan, it may be even more effective.

Specific weaknesses in the patient's academic background may be remedied, for example, in basic mathematics or English. In addition to making him more eligible to enter specific kinds of training, this may make him generally more employable after his discharge from the hospital. It may also help to relieve feelings of guilt about having terminated his education too quickly and may even prepare him for qualifying for tests to earn a certificate of equivalence of high school graduation. Such things may easily be overlooked but may be most important to the patient in his evaluation of his own worth.

The teaching of specific skills such as Braille and typing for the blind patient may be requested.

Some patients should be kept active, even though they may not feel like it. Among other things, they can be encouraged to report for regular educational therapy classes. The counselor may be able to help in motivating the patient to participate in this activity by relating it to a meaningful vocational program.

A specific patient, perhaps an arthritic, may maintain or regain dexterities and confidence at the same time that he is learning new skills or practicing old ones that will make him more desirable as an employee after his hospital discharge.

A patient for whom little counseling may be in order because return to his former occupation is both desired and feasible may learn an additional useful or required skill in preparation for return to his former job. The foreman may find typing useful in the preparation of reports or may learn more about effective supervision; the farmer can learn about new techniques and energy- or timesaving methods; the graduate student may learn a required language; the store manager may want to brush up on his bookkeeping.

Occupational Therapy

A good estimate may be obtained of how much dexterity the patient has left by performance in actual work situations.

Often the physician has referred the patient to occupational therapy for diversional activity. This allows wide application of occupational therapy techniques and projects. If the counselor wishes, he may request information on gross or fine dexterities, the manipulation of tools, or the knack for "fixit" types of activity on appliances.

Additional interest and hobby data can be obtained for use in the development of the vocational plan. Often the patient will develop new hobbies or reactivate old ones in the occupational therapy situation. Here the counselor can be particularly useful to the therapist by supplying some of the data he has accumulated on hobbies, extracurricular interests, club memberships, tinkering, and similar activities.

Independent estimates of intelligence, emotional adjustment, ability to follow directions, patience, inattention to details, muscular co-ordination, steadiness, and perseverance can usually be obtained from the therapist who works closely with the patient.

While participating in occupational therapy, the patient may be able to learn that he can do some manual tasks that he thought were impossible. This may greatly change his attitude and thinking in the counseling situation.

In the case of a severely disabled patient who is likely to have to work in a homebound situation after hospital discharge the occupational therapy activities may be closely coordinated with the counselor, since the patient will actually be learning his new occupation almost entirely in this section, supplemented perhaps by educational therapy activity.

This section is a good place for the patient to get an idea of how well he might like sedentary work, bench work, or other kinds of work situations. The occupational therapist is ordinarily quite flexible in his ability to work out new work situations for the patient.

Descriptions of the patient's co-operativeness, sense of humor, industry, and motivation are available to the counselor for the asking.

Quite often the patient will let the therapist know how he feels about the counseling relationship. The therapist sees the patient more often and for longer periods of time than does the vocational counselor, and the patient is likely to confide a good deal to the therapist. Armed with such information, the counselor may alter his approach and obtain more favorable results.

Sometimes devices that help in the counseling and educational process can be worked up for the patient by the occupational therapist. A skin patient, for example, whom the counselor wished to get started in educational therapy course work, couldn't wear his glasses because of the condition of his ears. It was possible to have the therapist work out a comfortable attachment which permitted the glasses to be worn. A device for self-feeding or for holding pencils may be worked up for a patient who has lost fingers on both hands. This may help to motivate the patient to plan an occupational future as well as make it possible for him to participate in more activities.

It is well to remember that the occupational therapist is anxious to do more than diversional work with patients and will welcome the opportunity to exchange information and plans with the counselor. The patient is also likely to feel that a greater effort is being made in helping him plan if all the services with whom he works appear to be aware of the progress that he is making.

Manual Arts Therapy

This is the service that can provide information on the patient's dexterities, his probable proneness to hazards, safety precautions that might be advisable, and other such practical considerations.

The patient's interest in commercial machines can be evaluated in this section. Interests in work with different types of materials and on different kinds of projects can be tested on a trial basis.

It will be interesting to the counselor to know how well the patient adjusts to an actual supervised shop situation. This is also a good place to find out whether or not he can tolerate standing or sitting for periods of time at a machine.

If the patient is very limited and desires machine work, it should be possible to determine what kinds of machines are most feasible for him to operate, what adjustments to the working situation will be required, or what special attachments, jigs, or special benches might be needed.

The patient's neatness, precision, planning, and speed in work with machine tools can be evaluated. A good record of accomplishment here can be useful in convincing an employer to give the patient a trial in his shop.

This section also provides a means for the patient to find diversion, develop hobbies, relieve tensions, and actively engage in work away from the ward and the bed situation. If these things can be linked to his vocational planning, they may be more effective, and the vocational planning itself may be viewed by the patient as activity which will result in actual job placement.

In the manual arts therapy section the counselor also can gain knowledge of what is involved in the operation of certain machines that are used industrially. In some hospitals this is stressed in the training of counselors, and although it is useful, the vocational counselor probably can get a more realistic picture by visiting industries and schools outside of the rather protected hospital environment, where activities on such machines are usually restricted to a relatively small number of operations. At the same time, the counselor will be making valuable contacts for the job-placement phase of the total counseling process.

Physical Therapy and Corrective Therapy

These sections offer the counselor good opportunities to secure information on how well the patient has really accepted his condition and how much he is motivated to get

well: for example, in his exercising, walking practice, use of prostheses, and self-care activities. The therapist has intimate and usually daily knowledge of the patient's efforts and trials in becoming accustomed to the new adjustments he must make before his discharge from the hospital.

Information as to how well the amputee can walk is essential to vocational planning. Often the counselor will want to obtain a pass for the patient so that he can visit an employment service, school, or prospective employer. He will need to know the distances the patient can walk and whether or not stairs and bus steps have been mastered before he asks the ward physician to consider the pass. To stimulate realistic vocational planning it is well to get the patient active in making some of his own contacts rather than always bring help to him.

The vocational counselor can learn a good deal about the patient's condition, progress, and remaining abilities by attending walking clinics, where the ward physician, orthopedic consultant, physical therapist, and the limb maker are evaluating walking progress and the fit and adequacy of the prosthesis being used. The counselor may be able to help in motivating the patient to expend more effort to learn to use the prosthesis, and he may get a realistic idea of just how effective the aid will be with this patient after he leaves the hospital. Knowing the patient's progress in these clinics will help in effectively timing the stages of the counseling process.

Additional information on personality traits in relation to vocational requirements can quite often be gained from therapists' observations of the patient's reactions to his prescribed physical therapy activities. What may seem to be rather simple activities to the nondisabled are often hard work for the patient and involve frustrations until he gains the strength or the knack for doing the activity successfully.

In these sections information can be gained on how well the patient will be able to take care of himself in ordinary

everyday activities both at home and on the job. Can he be relatively self-sufficient at home? Will he be a bother to the employer and his fellow employees on the job? It appears to be a mistake in planning to assume that constant help from fellow employees, for example, is either good for the patient or likely to last beyond the first few months on the job. The likelihood of a need for such things as ramps, special railings, elevator service, parking privileges, wide doors for wheel-chairs, and attendants can be better evaluated on the basis of reports from the therapist.

If the patient does not apply himself in difficult retraining activities and needs constant pushing, some of the underlying reasons can often be discovered in the counseling process. This will be necessary to ultimate successful job placement and will often help the therapist in the supervision of the patient activities the physician has prescribed.

It should be made clear that referrals to the various physical medicine sections are made by the treating physician and not by the counselor. The counselor, however, will find the physician amenable to suggestions on specific referrals if these contribute to the patient's treatment in the total rehabilitation plan. The counselor will find that most of the counselees referred to him have already been referred to one or more of the other professional services. His job will be that of co-ordinating his counseling information and the counseling plan with whatever knowledge the therapists have so that everyone is working most effectively toward the same end with the best available information.

THE SOCIAL WORK SERVICE

The effective vocational counselor will be very active with the hospital social service staff, both in sharing information and in making referrals and requests for specific assistance. Knowledge of the home situation, the wife's reaction to the patient's illness, the wife's knowledge of the part she may play in the rehabilitation plan, the kind of community the

patient comes from, the assistance given the family in economic planning and in actual economic aid, the availability of dietary facilities, aid in securing temporary housing, the availability of rest home or domiciliary facilities to the patient, the status of the family in the community, the assistance available for continued follow-up by a social worker, the availability of nursing facilities, help in obtaining such things as clothes or glasses—these are some of the kinds of information and service the social worker can give the counselor in planning with the patient. Obviously the social worker can be a most effective link in the counseling process.

Counselors in some hospitals may be disturbed to find much emphasis placed on psychiatric social work and the individual social worker more interested in estimating intelligence, evaluating personality dynamics, suggesting psychotherapy, and working generally from a psychoanalytic base. This will be disturbing to counselors who have come to lean heavily on the “old-fashioned” kind of social service information.

The counselor can make use of social service estimations of intelligence and personality factors as independent, and perhaps differently based, estimates for comparison with the data he has accumulated. This does not mean, however, that he should accept these estimates in place of securing data himself, using the tools he has been trained to use. In addition, the counselor probably will find that much information is available in the social worker's files on other points, such as family status or economic status, if he asks for it. It simply may not have been emphasized by the worker making the report. Reports on such activities as home visits or visits with the patient's wife usually will be made by the social worker if the counselor or another team member requests this kind of information.

From the vocational counselor's point of view perhaps the most important contribution of the social worker is the careful assessment of community and family attitudes toward the

patient and his tentative vocational plans, before the patient makes final decisions. Because of training and contacts the social worker is also in a good position to help the patient and counselor modify community and family attitudes before patient discharge, when this is desirable.

Hospital and field social workers can often supply the vocational counselor with follow-up information on his patients after they have been discharged. Home visits, general correspondence, and reports of co-operating agencies often contain data of interest to the counseling service in following its patients.

Since many patients are referred for a variety of reasons, the social worker is in a particularly good position to be alert to vocational planning needs of patients and to suggest vocational counseling to ward physicians and patients. This means, of course, that social workers and social work students should be kept informed of the procedures and goals of the counseling service.

Certainly this service must be one with which the counselor has good working relationships. Together they can co-ordinate counseling and community relationships to make the rehabilitation plan an effective one. The vocational counselor should take the time to learn about the theoretical leanings of the social service staff in his hospital so that he can know what is emphasized and how to contribute information as well as to obtain data for use in his counseling process.

THE NURSING SERVICE

Information from the ward nurse is often neglected by the vocational counselor. She has the closest continuous contact with the patient, has been trained to observe and record patient actions and feelings, and can often contribute more accurate information than most other hospital workers about the patient's daily adjustment to his condition, his treatment, and other patients.

The counselor may wish to inquire about co-operativeness

of the patient, acceptance of his new physical status, personal cleanliness, motivation to get well, acceptance by other patients, reliability, tolerance for pain, reactions to vocational planning with the counselor, reading habits, and reactions to visitors. These are a few items about which the nurse is likely to be well informed, particularly with patients hospitalized for fairly long periods of time. It will pay the counselor to get into the habit of checking with the nursing staff when he visits patients on the ward or visits to consult with the ward physician.

It is necessary that the counselor check with the nurse when calling for a patient to ascertain whether or not the patient has just completed a disagreeable test or painful procedure or is on some kind of drug therapy that might affect his reactions in the testing or interviewing procedures with the counselor. The fact that the patient is ambulant and that he comes to see you as requested is no assurance that he is in good condition to participate actively in counseling interviews.

S U M M A R Y

An earlier chapter stressed the importance of the development of effective interpersonal relationships by the vocational counseling psychologist. His relationships with the clinical psychology service was dealt with in the preceding chapter. The present chapter gives examples of how his interpersonal relationships with the other professional services can be productive. Emphasis has been placed on an exchange of information between the vocational counselor and the other professional services in the hospital or on the rehabilitation team.

Illustrations have been given of ways in which the counselor may participate with the other professional services in order to further the counseling effort and to contribute to the effectiveness of those services. Most emphasis has been given to effective relationships with the various

physical medicine and rehabilitation service specialties. Ways in which the social work service can be utilized effectively in the counseling process have also been indicated, and some attention has been given to the possible contributions of the nursing service to the counseling process. It has been pointed out that the ward nurse has information that is often neglected by vocational counselors. The ward nurse has the closest continuous contact with the patient, has been trained to observe patient reactions, and can often contribute valuable information.

6

Relationships with Hospital Administrative Services

There are certain divisions of the hospital which are not usually thought of as professional services and which have little or no direct dealings with patients as part of the total treatment effort. These are sometimes overlooked as contributors to the vocational planning process by the hospital counselor. If the counselor does not have close contact with these other administrative and special services and thinks of them only in terms of administering to the hospital staff, he should make an effort to learn how they might fit into the counseling process in his particular hospital. Often these other divisions are able to add much toward making the team rehabilitation plan successful.

THE PERSONNEL DIVISION

Placement within the hospital is a possibility that should be kept in mind, particularly in jobs such as housekeeping aide, hospital aide, elevator operator, messenger, or general clerk. The counselor should know what physical capacities are required for jobs in his own hospital and what the placement policies are with regard to physical disabilities. These policies are likely to be a composite of civil service regulations and the attitudes of the personnel physician and the management. If the counselor is alert to the possibilities, he may be able to place a patient within the hospital. An ar-

rangement should be worked out with the personnel officer to keep counselors posted on position openings.

The personnel division will probably have a better file of federal civil service openings in other agencies than will be found in the counseling service occupational file. The local secretary for the hospital board of civil service examiners is a good person to whom patients interested in federal civil service jobs may be referred. Since it is his daily responsibility, he probably will be better posted on such things as veterans' preference, physical demands, filing procedures, and closing dates than will the counselor.

The vocational counselor can also be useful as a professional psychologist to the personnel division and should offer his services. Co-operative consulting on such problems as questionnaires, surveys, ratings, morale problems, vocational counseling of individual employees, selection and prevention of turnover in such jobs as hospital aide and kitchen helper should be of value if the personnel officer desires it.

The counselor can improve his interpersonal relationships and contribute from his training if he serves willingly and actively on such personnel and administrative boards as those dealing with such things as efficiency ratings and incentives awards. Although it is not a part of personnel or any administrative service, the hospital credit union also provides opportunities for service for the counselor that should help him in establishing good relationships with other personnel.

THE SPECIAL SERVICES DIVISION

It may be very important in the total planning to ask that the special services division of the hospital make special efforts toward stimulating the patient's interest in entertainment and other diversional activities.

Volunteers can be very helpful in providing companionship, making purchases, filling out applications, typing, and performing many other services for patients. Often the vol-

unteer can give the counselor a good deal of additional insight into the patient's feelings, problems, and desires.

Special activities can be arranged for certain patients if the counselor thinks of requesting them. For example, a patient who likes music may be provided an opportunity to play regularly with other musicians. A patient interested in radio announcing may be able to work with a tape recorder. In the placement of an experienced radio announcer the making of a sample tape for prospective employers has been found useful. Arrangements might be made for a patient who is interested in being a projectionist or a recreational therapist to watch and sample some of this activity.

In Veterans' Administration hospitals, the special services divisions have begun to participate in making the transition from hospital to community as smooth as possible for the patient. They will probably have some responsibilities for follow-up after discharge. This program will be particularly important because of the increasing emphasis on the problems of older patients. Specifically, the special services officer will head a steering committee to enlist the assistance of service organizations in solving problems of the patient's adjustment to the community after his discharge from the hospital. These services on which the steering committee will work will be prescribed by what is called a functional committee, composed of representatives of the various professional services working with the patient (including the vocational counselor). When normal resources for patient assistance have been explored and exhausted, the steering committee will attempt to bridge the gap smoothly for the patient. These services may involve continued visits by a volunteer to rest homes or the patient's home, after the friendly relationship has already been set up in the hospital environment. Ramps may be provided for the wheelchair patient. Another type of project might involve securing adequate plumbing facilities for a colostomy patient living in a

rural area, or workshop or outlet facilities for a homebound patient who has skill but no resources. There are many possibilities for this program, which is just beginning to develop on a large organized scale, and certainly the counselor will be interested because in many cases they will bear directly on the vocational planning.

THE CONTACT DIVISION

The contact officer or information representative can help the patient to obtain most kinds of information pertaining to eligibilities under existing laws. Assistance is given in filing claims, in checking on the status of claims and disability allowances; and in providing such things as certification of veteran's status for use in filing for civil service jobs. These are just a few samples: The contact officer can help not only to minimize patient anxiety but also to relieve the counselor and other professional service personnel from involvement in the legal aspects of benefits, eligibilities, and such matters.

SERVICE ORGANIZATION REPRESENTATIVES

The counselor should know the representatives of the various service organizations both in and out of the hospital. Such things as representing the patient at disability board hearings, helping him to change joint accounts, helping him to find other services he desires in the hospital, notarizing papers, and renewing drivers' licenses are often done by the service organization representative. If the representative is seeing the patient, it is a good policy for the counselor to let him know what planning is being done for the patient, since a friendly attitude on the part of the representative can influence the patient's motivation a good deal. Moreover, he may be helpful in placement. One representative offered to circulate anonymously information on the physical capacities and abilities and interests of patients needing employment to the membership of his organization.

THE CHAPLAINS

These men can be of particular help in counseling where patients have religious problems or desire to continue their religious activities while patients. Although they have a certain confidential relationship with patients, chaplains are often willing to contribute insights into patient adjustment, emotions, and desires to the counselor. Often they can be helpful in the team effort to motivate a patient to participate in the total treatment plan.

THE LIBRARIAN

The librarian is often very helpful in assisting the patient and the counselor to supplement occupational information in the job planning process. It is also possible for the librarian to supply the patient with books that will give him new information or better fit him for the job to which he plans to return. The medical librarian is invaluable to the counselor in helping him to obtain professional materials on disability areas and occupational information. At the present time hospital librarians are interested in the possibilities of bibliotherapy and will be planning research studies and surveys, with the assistance of counseling and clinical psychologists, to evaluate the needs and methods of utilizing this technique with patients.

It should be mentioned in closing that the administrative services may not be found as separate sections as listed above. The library, for example, may fall under the special services division but is actually used as a separate service.

SUMMARY

Hospital administrative divisions that are not ordinarily thought of as contributing professionally in direct work with the patient are sometimes overlooked by the vocational counselor as contributors to the vocational planning process.

In this chapter examples of ways in which these administrative services can be utilized in the counseling process, and ways in which the vocational counseling psychologist may be able to contribute to the effective operation of these services have been specified. Some attention has been given to the new role in posthospital planning that is contemplated for the special services division and service organizations in hospitals, and the current interest in the possibilities of bibliotherapy in hospital library sections has been mentioned.

7

Relationships Outside the Hospital

THE REGIONAL OFFICE

In order to reach the final goal of helping his patient to achieve satisfactory job placement and good adjustment to his community after discharge from the hospital, the vocational counselor has to have good contacts in the community. First, he will need good relationships with the Veterans' Administration regional office counseling section and with the regional office training officers. There should be free interchange of records, opinions, reports of studies, and in-service training materials. The hospital counselor can be helpful in following the progress of regional office clients when they are hospitalized and can work for smooth passage of his counselees through whatever regional office legal procedures are required after discharge, if he maintains good personal relationships with their staff. Training officers can be assisted in making decisions on training status of hospitalized trainees and will reciprocate by contributing from their knowledge of job conditions and employment opportunities in specific areas when asked to do so. Although the hospital counselor is not responsible for as many legal decisions concerning training eligibility as is the regional office counselor, he still needs a source of information on such matters and a means of getting desired actions for his patients once they are ready to undertake outside training or actual employment.

THE STATE DIVISION OF
VOCATIONAL REHABILITATION

There will be a good deal of interchange of counseling data, disability data, and social information between the hospital vocational counselor and the counselors for the state division of vocational rehabilitation. Many patients who want and need training will no longer have eligibilities under laws administered by the Veterans' Administration and will need to apply to the state agency for assistance. It is well to have available the application forms for these agencies from the surrounding states as well. The author's experiences indicate that participation in the in-service training program for state rehabilitation counselors is stimulating and rewarding. Hospital and state rehabilitation counselors have many problems in common and should exchange experiences and data frequently.

THE STATE EMPLOYMENT SERVICE

The state employment service, through its regular placement procedures, its veterans' employment representatives, and its recently added special placement men for working with the severely disabled, will be especially important to the vocational counselor. He will want to have excellent working relationships with these placement people; they will probably constitute his best placement facilities for patients. He will also want to work out a method of follow-up so that he can know how effective the counseling and placement efforts were with the patient. Such follow-up reports should be made part of the patient's hospital file so that medical personnel will be informed of final results and a record will be available should the patient be rehospitalized. Letters, telephone calls, and personal visits will be required for effective relationships with the employment service representatives. Sometimes placement may be facilitated by having patients complete certain of the employment service forms while they

are still in the hospital. The new placement men working particularly with the severely disabled are able to visit patients in the hospital so that the process of finding a job can be started earlier and the transition to productive community life can be smoother. It is well to arrange a regular weekly schedule of visits of these men to the counseling service, if possible, so that counselors can plan to have certain patients available and also remind themselves of the presence of this valuable service. This scheduling also seems to make for better relationships with the placement man. He becomes familiar with the hospital and feels more a part of that particular rehabilitation team.

Contact should also be maintained with the technical services section of the particular state employment service to facilitate exchange of counseling data, familiarity with the kinds of data available in each service, and for technical information, for example, new developments in the use of tests like the General Aptitude Test Battery, and current listing of job openings and employment.

GUIDANCE SERVICES

Information and services should be exchanged between the vocational counselor in the hospital and other public guidance services in surrounding cities and school systems. Good relationships here also will facilitate discussion of additional high school work for some patients, the obtaining of high school equivalence certificates for qualified counselees, and the obtaining of test records and high school scholarship reports.

CIVIL SERVICE AGENCIES

The counselor should be familiar with the organization and functions of federal, state, city, and county civil service organizations. There should be an arrangement whereby the counselor is notified of current open registers and closing dates for open positions. When patients are interested in

these jobs, the counselor can insure more personal attention for the patient by making telephone calls or writing letters. The patient may easily be discouraged by relatively slow civil service machinery if this is not done. It is often possible to administer tests for a civil service agency to patients in the hospital who have previously applied for a position. Sometimes results of a patient's civil service test can be secured more quickly by the counselor; this is sometimes necessary before the counseling process can make progress.

PRIVATE FIRMS

The vocational counselor should know as much as possible about private firms and the operation of their personnel departments. Personal visits to firms seems the best method of achieving this. Active participation in community organizations also helps. Visits for trainees or the whole staff can usually be arranged, and these provide a good starting point for future placement contacts in behalf of a patient. If the hiring policies in individual firms are known, the counselor's placement efforts will be more realistic. He also will know where efforts to combat disability prejudice are needed.

COLLEGES

When the vocational counseling service is near a university or private college, the counselor should be familiar with the counseling service, the admissions procedure, and the employment bureau of the college. Data such as high school rank, college aptitude results, and college grades will supplement the locally developed counseling data. In cases where there has been some brain injury or deterioration, these sources often provide the best estimates of the patient's ability prior to the injury or disease. Cumulative records in schools are a good source of data. Arrangements for special services for disabled students can also be made; for example, the counselor might get reader service, an attendant, or a special parking permit for the patient.

PRIVATE EMPLOYMENT AGENCIES

Something should be known by the vocational counselor of the operation of private employment agencies in the community. Their experiences in trying to place a particular counselee may provide significant information. Their methods of establishing effective employer contacts may provide the counselor with clues he can use effectively.

SHELTERED WORKSHOPS

Sheltered workshops, if available, and organizations like the Goodwill Industries or the Salvation Army should be visited by counselors so that they are familiar with the physical plant and the operating procedures of the agency. Often such agencies can provide temporary work and housing for patients. Some of these agencies can also provide prevocational and work-adjustment training where it is indicated in the total vocational counseling plan.

VOCATIONAL SCHOOLS

Trade schools and business colleges in the area should be visited at least once, if possible, and the counselor should get to know the placement personnel in these schools. It is helpful if the counselor knows such things as what the school looks like physically and how difficult its courses are when he is helping the patient do tentative planning from a school catalogue. Patients, however, should still visit the school whenever possible before making a final choice.

SOCIAL AGENCIES

Although the vocational counselor will be requesting many different social agency services from the social worker, it is well when possible to become familiar with the services of the various community social agencies, if for no other reason than to know what to ask for in the way of special services. Veterans' homes, domiciliaries, and rest or nursing homes

will be interesting places to visit if the opportunity arises, so that the counselor will have some notion of what the patient will experience in these homes. The vocational counselor will usually be a member of boards considering the placement of patients in such facilities.

VETERANS' SERVICE OFFICERS

County veterans' service officers are valuable community contacts for vocational counselors. They will ordinarily be interested in the over-all plans of patients and often will have intimate knowledge of the patient's desires. They may be able to furnish information about how the patient is regarded in his community that will be useful in estimating probabilities of success in certain vocations. They can also help to co-ordinate community planning to aid severely disabled patients. Where it is desirable, they can help to supervise the patient's progress in achieving his vocational plan after he leaves the hospital. These men can be a good source of follow-up data on patients.

These are some of the outside contacts the counselor may find it necessary to develop and maintain. There are others, but these will give an idea of the breadth of knowledge the vocational counselor should have. He can do much to further the development of adequate community contacts by participating in professional, rehabilitation, and civic associations in his community.

SUMMARY

It has been stressed that the vocational counselor in hospital or rehabilitation work must have good contacts in the community if he is to help his patient to achieve satisfactory job placement and good adjustment to his community after discharge from the hospital. Although not all of the possible community contacts have been mentioned, those that are felt to be essential have been listed and a brief discussion of their utilization in the counseling process has been given. It

has been suggested that the vocational counselor can do much to further the development of adequate community contacts by participating in professional, rehabilitation, and civic associations in his community. The counselor cannot limit his activities and relationships to the hospital or the members of his rehabilitation team. He needs good contacts in the community to help his patients to achieve the final goals of vocational counseling.

PART THREE

Specific Disability Areas

8

Factors Common to Several Disability Areas

WORK HISTORY

Certain general statements that the vocational counselor will probably find applicable to several disability areas would appear to be in order at this point. For example, thorough development of past work history and hobby information is almost always necessary for adequate vocational planning with patients in any disability category. Among other things, it will help to establish energy output and work tolerance for the diabetic, the tuberculosis patient, and the heart patient. It will help identify stresses for the hypertensive and may provide suggestions for occupational readjustment without radical job change. It may suggest causes for skin conditions and neuroses or the degree of readjustment necessary for the paraplegic and point to allied areas of work or hobby expression still possible for him.

FAMILY ATTITUDES

Attention should be directed to family attitudes and family understanding of the patient's condition, through the social worker or doctor or the counselor himself. The success of vocational and total adjustment planning with patients in any disability area will depend partly upon informed family attitudes. The diabetic's wife should know about the importance of diet, energy output, and regular hours. The

rheumatic fever patient who has been fortunate enough to avoid much actual heart damage and who leaves the hospital feeling himself physically capable of many things may not feel this way long if he is protected from work and constantly warned about exertion by an overly concerned family. The asymptomatic hypertensive needs to avoid overconcern and to find relaxation at home as well as in his work. The family can be effective in helping the amputee and the paraplegic to overcome feelings of loss and possible feelings of social exclusion if it becomes able to accept the patient as a productive member of society and not one to be pitied and helped constantly. There are, of course, many other family factors that will bear on the patient's occupational planning, including the ambitions of the family for the patient, the wife's ability to plan, and the family's willingness to make new adjustments.

STRESS ON ABILITIES

It appears that for most patients in any disability area little is gained by stressing physical limitations imposed by the disability. Stressing positive abilities that remain seems to provide more fertile ground for occupational planning that is more than simple downgrading. Little is gained by stressing limitations with the diabetic when positive planning for well-regulated work and home activity will give him a relatively normal life. Much damage may be done by stressing limitations with the essential hypertensive or the cardiac patient. The cancer patient and the paraplegic are usually quite aware of their physical limitations; they may be much less aware of their physical abilities that remain to be capitalized on. The amputee ordinarily need not be particularly limited. Usually he needs to be motivated to achieve proficiency with his prosthesis and not to be reminded of limitations. To stress limitations with patients who have not yet found it emotionally possible to admit limitations may not be very effective. Other emotional problems blocking good adjustment to disability may need resolving by the counselor,

the clinical psychologist, or the psychiatrist. When a patient does not seem to understand certain essential limitations that his condition imposes on his activities, the physician rather than the vocational counselor might properly be the one to emphasize these limitations. With such patients, the prestige and authority of the physician may be required.

TIME FOR INITIAL CONTACT

Although there will be differences with individual patients, there does seem to be a general stage of hospitalization for specific disabilities in which initial contacts by the vocational counselor may be most effective. Fletcher (60) has discussed this in terms of the general treatment plan. Amputees should be contacted very early, before planned amputation if possible, if for no other reason than to give assurance of planning toward vocational productivity and good total adjustment after hospitalization. On the other hand, heart patients and hypertensives probably should not be seen until sufficient time has elapsed for evaluation of residual heart damage. If diabetics are contacted early, better planning for total controlled living may result in avoidance of future periods of hospitalization. Diet and insulin may be ineffective controls of the condition if occupational planning is neglected. Paraplegics should be seen early to make possible effective use of other services during a long period of hospitalization, but possibly the counselor should not expect acceptance and co-operation for a period of perhaps several months, during which period the patient may be trying to make a readjustment of his body image of himself. Tuberculosis patients are probably best contacted after the first or second month when sputum probably will be negative and they have had a chance to adjust to the idea of illness.

CONSULTATION WITH THE PHYSICIAN

Almost always in any disability area the counselor should consult the physician before seeing the patient. This is particularly true with cardiac, hypertensive, and cancer patients.

Even a disability such as a below-the-knee amputation, which seems to have fairly obvious implications, may be misleading if it has been complicated by some other medical condition. Not consulting the physician first can easily lead to the vocational counselor being played against the physician or some other medical team member by the patient.

INDIVIDUALITY OF THE PATIENT AND HIS CONDITION

There is no stereotyped approach applicable to all patients or even to all patients within one disability area. Each patient requires individual planning by the counselor. Medical information about disability areas and disease entities is necessary for the vocational counselor if he is to ask intelligent questions of the medical personnel and to understand the answers. Only then can he attempt to establish the individuality of the patient with whom he is planning, as the disease entity affects this patient.

PATIENT PARTICIPATION

Even with severe disabilities, attention must be given by the vocational counselor to planning and activity done by the patient himself. It is relatively easy to do things for the patient or to secure outside assistance for him. The effectiveness of this kind of aid has definite limits, however, and it would seem wise with any disabled person to encourage self-activity for more lasting posthospital adjustment. It may be relatively easy, for example, to get a community to furnish or even build a house for a severely disabled patient. Getting the community to allow him to live in it independently, to accept him as a normal citizen is sometimes a more difficult problem. The vocational counselor will wish to appreciate the emotional trauma that injury or sickness may have caused the patient, but he will want also to look at planning objectively. Often there appears to be too little emphasis on patient planning and work and too much emphasis on fur-

nishing aids to the disabled person that seem on superficial appraisal to solve his problem with little effort on his part. It has become customary, for example, to furnish guide dogs to blinded persons to lead them about in their daily activities. This looks like an ideal solution to the problems of the blinded, and it would not be questioned that these animals may provide company, certain feelings of security, and some usefulness in crossing intersections. More objective appraisal, however, may lead one to feel that the blinded person needs to know where he wants to go and how to get there if he is to "guide" his dog to that location. He learns this quite effectively by orientation with the long cane, which, although it provides somewhat less adequate companionship, does not require food or housing, need not be taken outside periodically, does not die, and is welcome in most living rooms and gathering places.

UTILIZATION OF OTHER SERVICES

Knowledge of different disability areas does not make counseling simply a matter of matching different sets of physical capacities with the physical requirements of jobs. Most patients also have emotional and personal problems. A knowledge of general counseling techniques is necessary, and alertness as to when to refer a patient to the mental hygienists is essential.

Effective hospital counseling with any patient will involve the resources of many professional people and will require good interpersonal relationships. There is almost always an effective way in which to utilize other paramedical services with patients in any disability area if the vocational counselor considers the problem. Use of these services may furnish additional information, help motivate a patient, serve as a deterrent to patient planning that is not well based, increase patient skills, or prepare the family for the patient's readjustment problems at home.

SUMMARY

Although specific disability areas require certain special considerations in vocational counseling with patients, there are general considerations that will apply to most or all of the areas. Some of these common factors have been discussed. It has been stated, for example, that thorough development of past work history and hobby information is almost always necessary for adequate vocational planning with patients in any disability category. The importance of family attitudes and attention to family understanding of the patient's condition have been stressed. The feeling has been expressed that little is gained by stressing physical limitations, and emphasis has been placed on stressing the patient's positive abilities. It has been suggested that when emphasis on limitations is required, this might more properly be the physician's function.

Experience has indicated that there is a most effective stage in hospitalization to be considered by the counselor as the proper time for his initial contact with the patient in a specific disability category. Examples have been given to indicate how this time for initial contact may vary for different disability areas. Consultation with the physician before the patient is seen for the first time is desirable in any disability area.

The need for attention to patient participation and planning has been stressed for all disability areas and for severely disabled patients. The idea has been advanced that although it is easy to do things for patients and to enlist the aid of others, these procedures have limited effectiveness, and it would seem wise to encourage patient activity for more lasting posthospital adjustment. Utilization of other paramedical services has again been stressed.

9

The Selection of Disability Areas for Discussion

THE PROBLEM OF SELECTION

To become well qualified to perform the task expected of him the hospital vocational counselor will have to become familiar with the knowledge available on a large number of disability areas and disease entities. Medicine covers a tremendous number of disease entities, however, and the breadth of the general medical field within which the counselor will find most of the relevant information he needs is shown by the fact that medicine has been forced to specialize in several circumscribed areas. Although psychology has also found specialization to be necessary, the vocational counseling psychologist in the hospital or the field rehabilitation setting has not usually found specialization in one or a few disability areas feasible. To be sure, there have been some vocational counseling specialists in traditionally emphasized areas, such as tuberculosis, the blinded, or the deaf. Specialization for counselors, however, has not been the rule in the other general medical and surgical disability areas.

Perhaps specialization for vocational counselors has not been feasible because of their short supply, the relative newness of hospital and rehabilitation counseling programs, and the relatively limited budgets of employing institutions. In the hospital setting, for example, the vocational counseling psychologist may find himself the lone counselor, or, at best,

he may have six or seven colleagues in a large general hospital setting. In the state rehabilitation programs, lack of adequate funds and personnel and the large geographical areas to be served have made specialization in each of the many different disability areas impossible. It seems obvious that, at this time at least, an attempt at competence in several disability areas rather than specialization in one or a few will have to be emphasized. Furthermore, review of the literature indicates that there are differences for the separate disability areas in such things as physical capacities, emotional reactions, and approach by the rehabilitation worker.

How, then, can the vocational counselor possibly become familiar enough with the several disability conditions to function effectively? The answer would seem to be that he will be learning continuously throughout his career and will never know quite all that he should. This seems to be dictated not only by the general breadth of the rehabilitation area in which he works but by the constant progress and change taking place in medicine and the paramedical professions. In a book of this kind, written to stimulate thought on how the procedures of an applied science may best be adapted to vocational counseling with individual patients in different disability areas, it would seem that emphasis should be placed on giving the vocational counselor (1) a realization that there exists in fields other than psychology, an extensive literature that is pertinent to his work; (2) some experience with how this literature might apply to vocational counseling in some specific disability areas; (3) some examples of the kind of questions for medical consultation that might best elicit medical information useful in vocational planning; and (4) some examples of where applicable literature may be found for specific disability areas.

OBJECTIVES IN MAKING A SELECTION

In presenting this analysis of vocational counseling with patients having specific disabilities, some selection of the

sample disability areas to be covered had to be made. Since it was felt too large an undertaking to attempt to make an analysis of the literature for all disability areas with which the vocational counselor in a general medical and surgical hospital should be familiar, the following three objectives were observed in making the selection:

1. Avoiding selection of disability areas in which vocational counseling has been discussed rather fully elsewhere or for which well-developed bibliographies pertinent to vocational counseling are already available;

2. Selecting as sample areas for this analysis those general medical and surgical categories from which counselors are likely to see patients rather frequently, giving consideration to those areas in which the counselor should be active in terms of the disability population served by the general hospital;

3. Presenting from each of the broad areas selected a discussion of a specific disability condition common to the area and presenting some of the more difficult kinds of problems found in the area.

It was felt that this manner of selecting the disability areas to be discussed should yield information immediately useful to the practicing vocational counselor, avoid duplication of existing materials, and avoid selection of areas based only on the author's particular needs or preferences. It was felt, also, that this approach might provide the vocational counselor with information on kinds of patients he is likely to see rather frequently but about whom not much has been written specifically for counselors.

BASES OF SELECTION

Areas Covered in the Literature

Disability areas that have been discussed rather fully in the literature with respect to rehabilitation, and for which there are well-developed bibliographies available to the vocational counselor, seem to include blindness and visual disabilities, hearing disabilities, tuberculosis, and psychiatric disabilities. In the area of blindness and visual disabilities, for

example, two publications of the Federal Security Agency (149, 150) list a total of 72 selected references on psychological problems associated with blindness and 20 psychological tests for use with blind adults. In addition, the U. S. Department of Labor's publication on selective placement (145) lists 16 references on vision. An excellent study of adjustment to blindness prepared by the Commonwealth of Pennsylvania (12), in 1954, lists 119 references. Lende's (90) annotated bibliography of references on blindness lists 2700 references. In the area of hearing disabilities, basic references are provided by Federal Security Agency and U. S. Department of Labor publications (for example, 145, 148), and Pintner *et al.* (106) lists 106 references on the deaf and the hard-of-hearing.

In the field of tuberculosis there have been marked changes in medical treatment in the last ten years. The old plan of treatment, described by present tuberculosis specialists as one including mainly "tincture of time" and "essence of patience," has been replaced by a plan which includes chemotherapy and surgery to remove diseased segments of the lung. Changes in treatment are still developing, and, for this reason, not much literature on the new methods has been published. For the counselor and the rehabilitation worker, however, the main changes appear to be that fewer patients with minimal amounts of the disease will have to make job readjustments and that patients may be able to participate more actively in counseling and prevocational activity at an earlier stage in their treatment. Much of what has been written on tuberculosis from a rehabilitation standpoint would appear to remain useful to the vocational counselor. There are still such factors to consider as the shock of the diagnosis, relatively long periods of hospitalization, and employer prejudice. Sample basic references for the counselor are found in U. S. Department of Labor and Federal Security Agency publications (142, 148). A helpful book by Pattison (102) on rehabilitation in tuberculosis includes 136 references. Another book by Kiefer (87), which reviews the lit-

erature from 1938 to 1947 on concepts of rehabilitation in tuberculosis, provides an excellent bibliography of 1007 references. In the rehabilitation of tuberculosis patients, a kind of team approach, including vocational planning and general rehabilitation, has been utilized for a number of years, although the activity of the vocational counselor in the team approach to other general hospital patients is a relatively new development.

In the psychiatric disability area a good deal of pertinent literature in psychology and psychiatry is available to the vocational counselor, who will have been exposed to much of this material and will be familiar with additional sources from his general academic training as a psychologist. Consideration of this area alone could easily fill a volume on hospital vocational counseling. One of the purposes of this analysis, however, was to assemble materials from various disciplines and to point out their applicability to vocational counseling in different disability areas. Although additional attention to vocational planning with psychiatric patients is both necessary and desirable, more attention might be given to areas where less source material is available to the counselor.

In the psychiatric area, familiarity with the different neurotic and psychotic reactions of patients, as well as some knowledge of the development and differences in schools of thought on psychotherapy, will be necessary for the vocational counselor who hopes to understand what the treating psychiatrist and clinical psychologist think about the patient and to visualize the role that vocational planning might play in the total treatment plan for the patient. Some useful basic references for this purpose might be those texts by Thorpe (135), Masserman (92), Brill (32), and Woodworth (170). Relatively recent books on medical psychology like those by Yacorzynski (176) and Weider (160) will also be useful. Of particular interest is a chapter on the meaning of normality by Mowrer (98), which presents views on this subject by rep-

representatives of several professional disciplines. It should be helpful to vocational counselors working with neuropsychiatric patients in understanding the concepts behind the opinions of other workers active with the patient and should help him to avoid narrow basic concepts of abnormality. Since he will be working more often and more closely with the clinical psychologist on these patients, the counselor will also want to know more about projective techniques, for example, from references like Buros (37) and Bell (14). The work of Dunbar (53, 54) on psychosomatic medicine provides an excellent review of the literature on psychosomatic interrelationship. Although these references are of particular concern to the clinical psychologist, the vocational counselor also must be aware of them in order to be able to make referrals to the psychiatrist when emotional components are so severe as to disturb procedures in vocational counseling.

On the basis of existing literature, it was felt that the areas of blindness and visual disabilities, hearing disabilities, tuberculosis, and psychiatric disabilities should not be selected for special discussion in this analysis.¹ The disability area of gastroenterology, including such conditions as ulcers and stomach complaints, also has been excluded from the present discussion on the basis of strong possible psychosomatic components that are treated in literature cited above.

Disabilities in the Hospital Population

To get an indication of the general medical and surgical categories in which counselors have a potential case load a tabulation was made of the number of patients, by medical service categories, who were discharged from a large general hospital. The tabulation included 3929 patients discharged from the Minneapolis Veterans' Administration Hospital during the six-month period from January 1, 1955 through June 30, 1955. The number and percentages of patients dis-

¹ Questions in these disability areas are considered briefly in Appendix A.

charged for each medical treatment service are given in Table 1.² Discharges rather than admission data were tabulated, since it is felt that discharges are more likely to represent firm diagnoses. Patients admitted with tentative diagnoses that were later altered on the basis of additional data would have been transferred to the appropriate treatment service prior to discharge. The medical treatment service designations give broad disability categories. It was felt that these discharge figures within broad disability categories reflect the patient needs being met by this large general medical and surgical hospital and give an indication of the areas in which there is most need and emphasis and the greatest likelihood that the vocational counselor will be called on to participate in total team planning.

Table 1
Patients Discharged (January 1, 1955–June 30, 1955)

<i>Group</i>	<i>Treatment Service</i>	<i>Number</i>	<i>Per cent</i>	<i>Number</i>	<i>Per cent</i>
A	Cardiovascular	325	8		
	General Medicine	302	8		
	Orthopedics	326	8		
	Neurology and Neurosurgery	296	8		
	Oncology (Malignant)	293	7		
	Endocrinology	137	4		
	Dermatology	114	3	1793	46
B	Psychiatry	261	6		
	Tuberculosis	136	3		
	Pulmonary Disease	181	5		
	Ophthalmology	71	2		
	Otolaryngology	61	2		
	Gastroenterology	210	5	920	23
C	General Surgery	775	20		
	Thoracic Surgery	40	1	815	21
D	Infectious Disease	69	2		
	Allergy	27	1		
	Urology	228	5		
	Hematology	38	1		
	Dental	39	1	401	10
Total		3929	100	3929	100

² The data in Table 1 were obtained from the records of the medical librarian of the Minneapolis Veterans' Administration Hospital.

In addition to showing the distribution of all 3929 discharges, Table 1 has been arranged so that it can be seen that the disabilities excluded from the present analysis (group *B*) represent 23 per cent of the discharges over the six-month period. Group *C*, surgery patients, did not appear to represent a good group for discussion because the general surgery area is very broad, and many surgical procedures require short hospital stays and leave little physical limitation and no new vocational problems. Examples of such procedures would be appendectomies, cholecystectomies, hemorrhoidectomies, and pilonidal cysts. Discharges from thoracic surgery represent only 1 per cent of the patients discharged. It should also be pointed out that the vocational counselor will encounter patients who have had more complicated surgeries, such as those involving cardiac problems and amputations, earlier in their hospital stay under other treatment services, such as the cardiovascular service or orthopedics.

Discharge figures shown for the services grouped under *D* in Table 1 are relatively small, representing only 10 per cent of the total discharges for the period. The urology service, with a fairly large percentage of discharges, has been shown in this group because it treats many patients who will be seen by the counselor as general medical cases, cancer patients, and neurological patients.

The remaining services, shown as group *A* in Table 1, represent those general areas from which it was decided to present disability discussions. This decision was also based on other data on referrals to the hospital rehabilitation board and vocational counseling cases completed, which will be presented later in this chapter. It can be seen that group *A* in Table 1 includes 46 per cent of the hospital discharges over the six-month period. Five of the seven general treatment areas have the highest percentages of patient discharges for all hospital services except general surgery, which was discussed earlier. Endocrinology, although it represented

a lower percentage of discharges, was included because, together with the general medicine service, it contributed 183 diabetics over the six-month period, or 42 per cent of the combined general medicine and endocrinology discharges. Diabetes, in addition, is felt to be a category which presents some of the many general medicine problems, such as drugs, diet, and energy output, important in both the treatment process and the vocational counselor's planning. Dermatology was included because even though it is a relatively small service in the general medical and surgical hospital and also may include patients with strong possibilities of psychosomatic overlay, the vocational counselor is likely to be called on frequently since the patient's physical and environmental limitations are frequently severe and many different approaches appear to be necessary in the treatment plan for these patients.

Team Planning Activity

Since the vocational counselor is active in the team planning done by hospital rehabilitation boards, a tabulation, by general disability area, was made of the number of patients presented to the board of a large general medical and surgical hospital for a recent period. In almost every instance the vocational counselor will be active in vocational planning with these patients and rehabilitation board activity, therefore, will constitute an important area of the counselor's activity in the hospital. The data on patients staffed by the Minneapolis Veterans' Administration Hospital Rehabilitation Board from December 11, 1953, to August 18, 1955, are given in Table 2.³ It can be seen that the areas selected for discussion in the present analysis, on the basis of the discharge figures in Table 1, include 89.5 per cent of the referrals to the rehabilitation board, and that the areas not

³ Data in Table 2 were tabulated from records of the secretary of the Minneapolis Veterans' Administration Hospital Rehabilitation Board.

selected for discussion include only 10.5 per cent of the referrals to the board. It will be noted that the figures for the psychiatry service are not included in Table 2. This reflects the fact that less formal ward teams are active on the psychiatry service and that these patients are not referred to the rehabilitation board in this hospital. Although this somewhat reduces the strength of the figures given in Table 2, the table nevertheless shows the kinds of activity in terms of disability areas which board activities require of the vocational counselor.

Table 2
New Patients Staffed by Rehabilitation Board (December 11, 1953–August 18, 1955)

<i>Disability Area</i>	<i>Number</i>	<i>Per cent</i>	<i>Per cent</i>
Orthopedics	30 *	34.5	
General Medicine	18	20.7	
Cardiovascular	10	11.4	
Endocrinology	7 †	8.0	
Neurology	6 ‡	6.8	
Dermatology	4	4.6	
Cancer	3	3.5	89.5
Gastroenterology	4	4.6	
Tuberculosis	2	2.3	
Pulmonary Disease	1	1.2	
Hematology	1	1.2	
Ophthalmology	1	1.2	10.5
Total	87	100.0	100.0

* Includes 10 amputees.

† Includes 5 diabetics.

‡ Includes 4 paraplegics.

Activity in the Counseling Service

A tabulation, by treatment service, shown in Table 3, also was made of 100 vocational counseling cases completed in 1955 in the Minneapolis Veterans' Administration Hospital. It can be seen that over half of the patients referred who completed counseling were treated in the hospital for medical conditions in the general areas selected for discussion in the present analysis.

Table 3
Distribution, by Treatment Service, of 100 Consecutive
Counseling Cases Completed up to August 1, 1955

<i>Treatment Service</i>	<i>Number</i>	<i>Per cent</i>
General Medicine	16	
Cardiovascular	7	
Endocrinology	1	
Dermatology	5	
Neurology	17	
Orthopedics	9	55
Psychiatry	22	
Tuberculosis	18	
Pulmonary Disease	3	
Gastroenterology	2	45
Total	100	100

SPECIFIC DISABILITIES SELECTED

The specific disabilities to be discussed were selected to represent problems of counseling in the general treatment areas. Diabetes presents some of the problems found in general medicine and endocrinology; amputees present some of the more difficult problems in orthopedics; heart patients represent the cardiovascular area; hypertensives represent both the general medicine and the cardiovascular areas and were felt to require an approach different from that used with the heart patient; the paraplegic represents the neurological area; cancer patients present a special challenge and represent the service shown as oncology in Table 1; and skin patients present the problems of dermatology.

Although it is difficult to get specific, clear-cut data on which to base a selection of areas to be discussed, it is felt that the data that have been presented in broad disability area terminology point to the likelihood that the vocational counselor in a general hospital setting should be familiar with the disability conditions that have been selected for discussion in the chapters that follow.

SUMMARY

Seven disability areas were selected for discussion in this analysis. The literature of rehabilitation, the patient population of a large general hospital, and the caseloads of the hospital rehabilitation board and the counseling service in a general hospital were used to indicate general treatment areas for discussion. Specific disabilities were selected to present problems of counseling characteristic of the general treatment areas. In the selection of disability areas for discussion the author attempted to select those areas from which counselors are likely to see patients rather frequently and in which they should be active. At the same time, selection of disability areas where rehabilitation and counseling literature is already rather extensively developed was avoided.

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10

The Diabetic

PROBLEMS PRESENTED BY THE CONDITION

For the hospital vocational counselor, the ordinary diabetic may not appear to present as difficult a counseling problem as do some of the other disabled patients. Kessler (83, p. 210), in 1947, stated that since 50 per cent of all diabetics require no insulin, there is no need to establish any special restrictions to their work activity. For those diabetics who require insulin, however, occupational restrictions of some sort are likely to be necessary. Another source (145, p. 75) indicates that those diabetics who follow their insulin and diet schedules faithfully do not require specialized aid in securing a job unless they encounter employer resistance or unless their condition warrants change from heavier to lighter work. It would seem that the diabetic who practices good medical and personal care can do many kinds of jobs successfully. The counselor must remember, however, that he is working with an individual patient, who may or may not be properly motivated to remain well and who has his own individual diabetic condition. In this, as in most other disability areas, it is dangerous to apply a general set of rules to all patients falling in the disease category. Such a practice by the counselor can easily impose too much or too little restriction on the patient's vocational activity and may be responsible for unnecessary personal and physical maladjustment.

Generally speaking, the diabetic presents fewer initial

counseling problems because he ordinarily comes to the counselor well aware that he has an established diagnosis of diabetes. He has been well briefed on the importance of diet, and in many cases insulin, for the control of his disease, and he has been instructed in the importance of personal care. For these reasons, diabetics as a group, as Bridges (31, pp. 216-219) points out, are usually good examples of personal cleanliness and self-discipline. They may also have good reasons for wanting to control their condition, since most of the diabetics with whom the hospital counselor works are referred specifically because they have known the effects of such things as improper care, lack of early diagnosis, too much activity, inadequate diet, or improper insulin dosage, and have been hospitalized as a result.

MEDICAL INFORMATION FOR THE COUNSELOR

In order to individualize his counseling procedures and to be able to consult intelligently with the ward physician, the vocational counselor needs to have some medical knowledge of the disease. Only a brief description will be given here. Interested counselors can find more complete descriptions of studies of the function of the pancreas in diabetes mellitus, the effects of insulin, and the importance of the roles of the pituitary, adrenal, and thyroid glands in such reference works as Macleod's (10, pp. 759-770). Our purpose here is not to give a complete medical picture but to describe the condition sufficiently to allow the counselor to work effectively in vocational planning with patients.

The diabetic patients the vocational counselor is most likely to meet will be those persons who have *diabetes mellitus*, popularly termed *sugar diabetes* (31, p. 216). Dorland (52, p. 419) defines diabetes mellitus as

a metabolic disorder in which the ability to oxidize carbohydrates is more or less completely lost due to faulty pancreatic activity, especially of the islets of Langerhans, and consequent disturbance of normal insulin mechanism. This produces hyperglycemia, with resulting glycosuria

and polyuria giving symptoms of thirst, hunger, emaciation, and weakness and also imperfect combustion of fats with resulting acidosis, giving symptoms of dyspnea, lipemia, ketonuria, and finally coma. There may also be pruritis and lowered resistance to pyogenic infections.

Bridges (31, pp. 216–219) simplifies this for us by indicating that when the pancreas does not secrete enough insulin, the excessive sugar in the blood is called *hyperglycemia*, sugar appearing in the urine is termed *glycosuria*, and the increase in amount of urine is referred to as *polyuria*. The polyuria resulting from the effort of the kidneys to remove extra sugar from the blood in turn causes thirst and dry, irritable skin because of water loss.

Less common, but also encountered by the hospital counselor, is the patient with a diagnosis of *diabetes insipidus*. This condition is defined by Dorland (52) as “a metabolic disorder, marked by great thirst and passage of a large amount of urine with no great excess of sugar. It is often attended by voracious appetite, loss of strength, and emaciation.” In this condition there is not the pancreatic disturbance of sugar metabolism. Instead, as Hathaway (73, p. 116) points out, the condition results from degeneration or lesions in the hypothalamic nuclei. Yarcorzynski (176, p. 388) points to the function of both the pituitary and the hypothalamus in this condition. For the counselor the implications of this disease will be different, since he will not be concerned with such things as the sugar metabolism as it relates to energy output or with the possibilities of insulin shock. He still may have an emaciated and weak patient with limitations and will want to consult the physician on the individual restrictions. This section, however, will be concerned with the more common condition of diabetes mellitus.

Bridges (31, pp. 216–219) points out that when not under medical care and practicing good personal hygiene, the diabetic has lower resistance and is more susceptible to pulmonary tuberculosis, pneumonia, skin diseases, pimples, boils, and eye diseases such as cataracts, inflammation of the retina,

hemorrhage of the retina, and occasional loss of vision. He is also likely to have slow or defective healing of wounds, cuts, or skin breaks, and nonunion of bone fractures. Gangrene is a prominent hazard in injuries to the legs and feet. This is especially true for older diabetics when there is a tendency toward arteriosclerosis causing poor circulation in the legs, feet, and toes. Bridges also points out that diabetic coma is no longer as serious a hazard if the person knows he's diabetic and has been properly instructed. Coma can result from giving up or taking too much insulin, or from improper diet, unusual exercise, or an infection without additional insulin. It has an onset described as slow, preceded by sickness and nausea; it has a fast course, with recovery or death usual in 24–36 hours. In this regard, diabetics should carry identification to insure quick treatment and to avoid improper diagnosis.

The interviewing guide for diabetes, published by the U.S. Employment Service (140, p. 2), states that certain diseases are likely to develop more easily or earlier in diabetics than in nondiabetics. Hardening of the arteries, with manifestations in the heart, brain, kidneys, or lower extremities, is the complication most often associated with diabetes. Injuries to the feet and legs may result in gangrene and amputation. Complications often found present are heart disease, eye troubles, respiratory infections, skin troubles, and amputations. In severe cases of diabetes (140, p. 1) the body can no longer obtain needed energy from carbohydrates and must draw upon protein and fat as a source of energy. This usually results in loss of weight and strength.

Untreated or improperly managed, the disease has severe implications. Most diabetics under care can be as good workers as nondiabetics (31, p. 218). Use of insulin, early diagnosis, research into the mechanisms of diabetes, and education of the patient and the public have greatly increased the horizons for the diabetic for both life and employment.

Pintner, *et al.* (106, pp. 290–294) tell us that in 1933, twenty-six out of every 1000 female infants and fifteen of every 1000 male infants would succumb to diabetes mellitus. In 1937, one in every 8000 children under fifteen years of age in the United States was diabetic. In 1941, they state that the incidence of diabetes is increasing in this country. Before the use of insulin, most diabetic children were underweight, and many were below normal height. Now they more nearly approach normal height and weight. Pintner, and his associates, again surveying existing studies in 1941, concluded that the evidence points to normal intelligence and satisfactory school adjustment. Kessler (83, p. 210) estimates in 1947 that one in every 100 persons is a potential diabetic. The present figure is probably higher, with more diagnosed cases following increased public education and organized appeals to the public to participate in simple tests for diabetes. Kessler points out that although the outlook for life and active working capacity was very dark, and for children prognosis was generally fatal, now “the child can look forward to adulthood,” and the “adult can look forward to a life of full activity with little restriction of a major character.”

The most effective control of the disease is obtained when the physician is able to find a nice balance in insulin, diet, and exercise (140, p. 2). Exercise is important; it tends to keep the diabetic's weight and blood sugar normal. Expenditure of the right amount of muscular effort helps the diabetic burn up excess sugar and, in that respect, reduces the amount of insulin required (83, p. 210). On the other hand, it is highly desirable to have physical demands of jobs quite constant from day to day, since variations may require the diabetic to change or vary his insulin dosage (31, p. 219) and run the risk of disturbing his established balance. To maintain a fine balance among insulin, diet, and exercise, the controlled diabetic's life must be well regulated, with each day's total activity approximately the same.

This is not the same as saying that he must do light work.

Following the prescribed diet is important. Diet as well as insulin dosage may have to be adjusted because of change in the activity of the patient if the job or its physical demands are changed (140, p. 4). The degree of dietary restriction depends upon the condition of the patient and the physician's views on diet. Some doctors are inclined to allow the patient a "liberal diet" as long as his weight remains normal (140, p. 2).

The amount of insulin, where required, varies with the individual condition and differences in circumstances (31, pp. 216-219). Most cases respond readily to treatment. The effect of the insulin dosage and the period of effectiveness vary with the type used. With improvements in insulin, it is possible now for the usual case to require only one injection per day (140, p. 8). For the patient using insulin, the dangers of insulin shock, with its dizziness, faintness, or even loss of consciousness, must still be considered (83, p. 210) in intelligent vocational planning.

Although the hospital counselor will generally be working with patients who have achieved or will achieve maximum possible control of their diabetes, knowledge of the effects of the uncontrolled condition will give him leads as to activities and environmental conditions to be planned for or avoided. Knowing the mechanism of the disease should help in planning to insure maintenance of control. And, after control has been achieved medically, helping to evaluate the likelihood that this particular patient will follow his prescribed routine on his own is an important counselor function. Additional planning for extra safeguards may be required for some patients, although it is quite unnecessary and may even be harmful for others. Helping a patient find employment which stresses cleanliness or adherence to schedules, for example, may be necessary for some patients.

Determining how well the patient has been educated in matters concerning his disease is important. The counselor

can help to consolidate the patient's learning and can be effective in adding to or co-ordinating the teaching effort. The patient may have had his condition explained to him in detail but understood little of what had been said. The counselor is more likely to know more intimately the learning capacities of the patient than is the busy ward physician. Barker *et al.* (11, p. 313) point out that in diabetes, tuberculosis, some cardiac conditions, and in nutritional deficiencies, treatment is largely a problem of educating patients. They also point up the fact that as medical practice becomes increasingly preventive, treatment becomes more and more an educational problem.

QUESTIONS TO BE RESOLVED WITH THE PHYSICIAN

Bearing in mind that prescribed activities and limitations will vary with the individual patient, some sample questions for which the vocational counselor may wish to find answers, from the physician, from the medical case file, and from the information developed in the counseling process, are the following:

What sort of dietary program must the patient follow to maintain control of his condition? Can this easily be achieved in most eating situations, or is it advisable that most of the meals be taken at home? Has the physician, dietician, or social worker explained the importance of dietary regulation to the wife, mother, or person who supervises the patient's meals? The vocational implications of the answers to these questions and those which follow are of primary concern to the counselor and to the counselee.

Is this patient particularly vulnerable to ill effects from injuries and infections? How serious might an otherwise relatively minor industrial accident (for example, to an extremity) be in this patient's case? Does the patient also have peripheral vascular difficulties on which the physiatrist might have additional information (for example, conclusions from

oscillometer readings on the amount of blood flowing to the extremities, which would bear on the danger of infections, injuries, or surgery to the extremities)?

Has he other physical defects, which might lead to infections, which he will or should have corrected before starting employment or training? Does he know about them? Is his employment likely to be interrupted in the near future by recall for correction of such conditions?

Does he observe rules of good personal care? Would certain kinds of employment situations be more conducive to this? Would certain kinds of employment interfere with or preclude good personal care?

Does he seem to be emotionally upset by the knowledge of his condition and the regimen he must follow to keep the condition under control? If he takes insulin, is he informed of the possible consequences of improper dosage?

Is he limited in the heaviness of the work he can do, or is the problem mainly one of finding work that requires a rather constant daily energy output? How "brittle," or difficult to control, is his diabetes?

If alcohol is causing difficulty in maintaining control of the patient's condition, has it been discussed with him, and how does he accept this? Is psychotherapy or referral to Alcoholics Anonymous advisable and desired by the patient? Does he know he has a real problem in this regard?

With this patient, how important is it to have regular hours of work and to avoid spurts of work or outside activity? Will late shifts or rotating shifts be apt to cause trouble?

For this patient, how much should his safety and that of others be considered because of possible dizziness, faintness, or loss of consciousness? How does this affect his candidacy for jobs in high places, near dangerous equipment, or requiring the operation of vehicles or other moving machinery?

Does he take his condition more seriously than he should? Is there a neurotic overlay of additional symptoms? Does

emotional stress complicate etiology or control of this patient's condition?

If possible control at this time is not good, should the patient work at all? If not, is there the possibility of training or prevocational work that might keep him occupied and have usefulness at some future date?

If there are other physical involvements, have the physical limitations imposed by them (for example, visual, cardiac, orthopedic) been carefully considered?

Which conditions or hazards which might lead to infections and complication of control (for example, dirt, wetness, unguarded machinery, moving objects, handling acids or hot metals, and exposure to eye hazards) should be considered with this individual?

These are a few of the questions the counselor will want to consider in his consultations with other hospital personnel and with the patient.

COUNSELING CONSIDERATIONS

In counseling with the diabetic certain other considerations should be borne in mind. Diabetics, as a group, appear to have normal intelligence and a history of satisfactory school performance, as Pintner *et al.* (106, pp. 290-294) concluded. Brown (33, pp. 175-184) found that in spite of poorer school attendance, diabetic children compare favorably with their nondiabetic siblings. Hathaway (73, p. 218) states that some data have indicated that intelligence is increased in diabetic children, but he feels it unlikely that this finding will be substantiated. There is little reason, in any event, to expect significantly lower or higher intelligence for a group of diabetics than for a general population group.

Pintner *et al.* (106) also state that diabetes is more prevalent in urban than in rural areas, more frequent in the higher social classes, and least frequent in persons engaged in hard manual labor. Whether this is really true or whether

urban groups and higher social and occupational groups have better medical facilities and better diagnosis is a question. However, when these general statements hold true for individual cases, the counselor's task is made easier. A greater variety of job adjustments are possible in urban areas; individuals from higher social classes may be less likely to violate work output and dietary regulations to supplement inadequate incomes; and more brittle diabetics often have to avoid hard manual labor.

If the patient should plan to change his job or to get more regular hours, the counselor must help him to plan realistically within the labor-market framework of the community to which he plans to return. It does little good to plan for light work, for example, and to have the patient in agreement but returning to a small logging community or a mining or farming area with little in the way of manufacturing or business activity.

Yacorzynski (176, p. 83) feels that the evidence "points to the possibility that emotional factors might be important in the incidence of diabetes mellitus." Wolff (168, pp. 342-343), reviewing a study, states that "the onset of the diabetic disorder occurred after a period of stress characterized by the loss of loved persons, objects, or relationships which the patient regarded as indispensable." Again he states, "Even in their infancy and childhood they reacted to such stresses as the illness of the mother, the birth of a sibling, or rejection by parents with an increase in appetite, increase in weight, and demand for sweets." He feels that the diabetic patient reacts as though food and security were identical and develops a physiological reaction appropriate to starvation at a time when he is exposed to deprivations other than those of food. Diabetes is viewed as an adaptive reaction which, for short periods, might be harmless but through long continued use is associated with the irreversible changes of function characteristically found in diabetes. He further emphasizes the importance of stress in diabetes and states

that "life crises in the diabetic may evoke an exacerbation of the pattern of fat and ketone utilization leading to ketosis, coma, and death." Whether or not the particular counselor feels that there is now enough evidence to support the importance of emotional factors in the incidence of diabetes, these suggestive statements will probably make him more alert to the possibility of previous emotional crises that may make it easier to understand the patient's total effectiveness at the time of counseling. Referral for psychotherapy and planning for avoidance of future emotional trauma might also be in order in individual cases. In this respect, the counselor should be alert to the possible importance of emotional facts. On the other hand, he must be careful not to go overboard and look on diabetics as having basically just an emotional adjustment problem; they have a very real physical problem to face.

Brown (33, pp. 175-184), working with diabetic children and their siblings, found no striking differences on a personality test. The only personality changes which parents reported were increased irritability and excitability. Hunt (76, pp. 590-591) reviews a study showing that children who developed diabetes at an early age accepted the handicap as a part of growing up with less emotional upset than did children who developed the disease after the age of seven or eight years. The adult patient, however, has had much more opportunity for experience with his condition and education concerning it. As Kanner (80, p. 53) indicates, the diabetic child does not usually have any awareness of being ill; he must take the word of someone else for it. "He must live up to certain regulations, the rationale of which he does not understand." Kanner points out that a blind child will not deliberately run into obstacles that might hurt him; but diabetic children often steal food they have been told will be injurious to their health. In occasional intellectually dull diabetic patients this lack of understanding may be a real challenge for the counselor in trying to further educate

the individual and in finding particularly suitable job placements. The dull individual, not fully understanding his condition and not appearing physically different from others, may tend to conceal its existence, even from himself, and may not follow instructions.

Studies of insulin dosage and blood-sugar tolerance point up interesting psychological results for the vocational counselor working with diabetics. Hathaway (73, p. 209) states that improper insulin intake may result in mild hyperinsulinism, during which there may be apathy, blank spells, or automatic periods. Teachers or parents may mistake these for lack of interest or willful inattention. The counselor, in order to avoid too hasty or incorrect appraisal of the interest and motivation of his patient, should be aware of this possibility. This situation is quite possible in the hospital, where insulin dosage may be varied while the patient is working in the counseling process, since the physician at this time is trying to establish the correct level of dosage for best control of the disease.

Yacorzynski (176, p. 401) states that commonly observed psychological symptoms in hyperglycemia are depression and emotional instability. In hypoglycemia there is likely to be fatigue, irritability, restlessness, and exhaustion. The patient may become easily upset and may carry out acts without being aware that he is doing so. Strecker *et al.* (124, p. 196), discussing toxic reactions, feel that "in diabetes there may be depression, with self-depreciation and self-accusation."¹ Shock (76, pp. 590–591 and 121a), discussing curves of blood-sugar tolerance in psychotic patients, states that "it appears that depressed function of the vegetative processes involved in carbohydrate metabolism is associated with mental depressions." In counseling with the diabetic, then, the vocational counselor will want to learn from the physician all

¹ By permission from *Practical clinical psychiatry*, by E. A. Strecker, F. G. Ebaugh, and J. R. Ewalt. Copyright, 1951, Blakiston Div., McGraw-Hill Book Co.

that he can about the present physiological state and amount of insulin dosage. He will want to learn of the interest and reaction of the patient to other hospital activities. He will want to evaluate personality factors, interest, and motivation with great care before he makes judgments about the vocational possibilities for the patient. He may wish also to postpone some of his testing until a suitable stable period of insulin dosage has been established and the patient is not likely to be experiencing special psychological symptoms.

It is observed by Yacorzynski (176, p. 293) that "a number of organic conditions may appear in a family stock more frequently than in the general population. This appears to be true of some allergies, cardiovascular disorders, diabetes, and other conditions. . . . It is not possible to state what is actually inherited to predispose the individual to a particular type of pathology." Although this hereditary factor does not appear to be clearly established, the counselor may wish to learn of any family history of the disease. If there is one, and if other members have followed similar patterns in their disease, some inferences as to possible future adjustments of the patient to certain job routines may be possible. Possibly most important here would be some of the notions other family members have about what the patient can and cannot do, his experience being compared with their experiences with the same condition.

The U.S. Employment Service interview guide (140, p. 3) stresses the importance of observing dates of treatment, diagnosis, and shock as indicators of duration, co-operation, adjustment to control, and the likelihood of insulin shock or coma. The number of job changes and their nature may also indicate difficulty of control or failure to observe measures prescribed to maintain control. Study of these factors may help the counselor and the patient in choosing a vocational plan. It should be remembered that some job changes may have been wise moves on the part of the diabetic, made purposely to maintain his prescribed routine. Some job

changes may indicate lack of job satisfaction or skill, with the diabetes serving as the excuse for the change. Skillful investigation of these possibilities may lead to better patient understanding of the actual extent of his disablement.

Thorough development of work history, hobbies, school experiences, and military experiences would seem desirable in order to capitalize on past experience and thereby avoid possible emotional stress in adjusting to new job situations. This may facilitate better motivation to conform to necessary routine, and some of the guesswork will be taken out of the patient's probable adjustment to a certain energy output in his work routine.

For some diabetics who seem unlikely to lead the necessary regulated life, it may be advisable to devote special attention to suggesting work that demands regulation and still has appeal because of challenge, prestige to be gained, salary, or other factors. It would seem wise to help the diabetic to plan to learn or to utilize a rather specialized skill or knowledge if possible. This may reduce the likelihood, in times when the labor market is tight, of his being placed in the position of the laborer, odd-jobs man, or jack-of-all-trades who is more likely to be confronted with constantly varying energy demands. If it seems necessary or desirable that he work with machinery, perhaps placement in larger plants with active safety programs and practices should be considered.

Most writers stress or imply that medical supervision is necessary, that this medical supervision should include the physician at the place of employment, and that identification of the person as a diabetic is desirable. This poses a placement problem, since some diabetics pass company physicals without detection but have difficulty when they mention their disease. It would seem wisest, because of possible dangers involved for patient, employer, and fellow employees, that the employer be aware of the patient's medical condition. This means the patient may need special placement assistance because of employer prejudices. Kessler (83, p. 210)

points out that prejudices regarding employment of the diabetic are unfounded. The improvement of insulin has reduced the number of injections of insulin required. Generally, once a day before breakfast is sufficient, and time out from work is not required. There is no need for time out for specimens, since this can be done at home. Special eating arrangements, if necessary, are usually not difficult to work out. Kessler states that "while diabetes is never cured in a technical sense, there is no reason why the diabetic cannot become a productive member of society."

Clerical, general office, administrative, professional, and salesclerk types of work, if otherwise advisable and acceptable, probably represent some of the occupational areas most compatible with the limitations of, and possible hazards to, the diabetic patient and his fellow workers. Many different kinds of work, however, are possible for individual patients if there is careful evaluation of individual abilities and job requirements. It is well to think in terms of both present and probable future requirements in the job area rather than of a specially tailored placement with one employer. The diabetic will have to adjust even after he has left the relatively sheltered counseling and placement process.

ILLUSTRATIVE CASE STUDY

The following case study admittedly is not representative of diabetic patients. It has been selected deliberately, however, to illustrate the nature and variety of problems that may be encountered and the number of persons and agencies that may become involved in the counseling process.

Patient A: diabetes mellitus; age, 31; modal prior occupation, farm-hand, general.

Counseling Developments

This patient is a thirty-one-year-old white male veteran of World War II who has been admitted to the hospital four times for treatment of diabetes

Possible Implications

Had the patient been referred during his first or second hospitalization, it is entirely possible that an earlier

Counseling Developments

mellitus. He has no service-connected disability and no eligibility for rehabilitation training sponsored by the VA. He has no remaining eligibility for GI training benefits. The veteran was not referred for vocational counseling assistance until his third admission for treatment.

The ward physician described the patient's diabetes as moderately severe and recommended avoidance of heavy work and exposure to infections and maintenance of a relatively constant daily energy output. Appropriate diet was, of course, also stressed. The patient seemed to accept the importance of observing these medical restrictions.

In the initial interview the patient seemed to sincerely want counseling assistance. He appeared to have at least average general mental ability. He seemed, however, almost too happy about his hospital situation and too co-operative for one who did not yet know how the counseling situation might affect him. He also left the impression that he might not be as sincere and dependable as he would have us believe. He indicated immediately that he wanted to find work as a truck driver or as a farm-equipment partsman. He also indicated that his wife was not very happy in the small community in which they lived. After a brief general explanation of how counselors try to assist patients in planning their occupational future, the interview was terminated with the sug-

Possible Implications

start on vocational planning might have saved a good deal of lost time and money—importance of publicizing counseling.

More physical restrictions than the usual diabetic referral, where constant energy output is desired but avoidance of heavy work is not specified. More difficult condition to control.

Counselor needs to determine how heavy the work can be.

Underestimation of general mental ability probably because the patient lacked academic polish.

Token acceptance of counseling and obedience to physician's request; likes the hospital and does what he feels is expected of him; work preferences indicate patient is not really considering an occupational change.

Reference to wife may be his way of expressing his own dissatisfaction. What kind of person is the wife?

Allowing time to think over counseling gives the patient a chance to obey the doctor by reporting initially, and to signify some acceptance of

Counseling Developments

gestion that the patient return in a day or so if he wished to do some planning with us.

The patient came back to continue counseling, and it was learned that he is married to a girl he met while overseas. He has two small children, ages five and three. He is buying his home in a very small farming community.

The parents live nearby and have helped the family during periods of financial stress. The patient has also obtained aid from public social agencies. He expressed concern for his family while he was hospitalized but seemed in no great hurry to leave the hospital.

The patient completed nine and a half grades of school but required over eleven years to do so in a small rural school. He indicated that he disliked grade school and did not work hard. He had no business or trade school training but used two years of GI Bill training as an assistant manager of a lumber yard and two more years as a farm-machinery mechanic. After this four years of training, he worked only six months as a farm-equipment partsman. He did not put any of his training to actual use in employment. When he made a change in his VA-sponsored training, he did not seek vocational counseling assistance, although he was eligible to participate in it.

Preservice work experience was limited to heavy work as a farmhand, me-

Possible Implications

counseling if he comes back on his own to continue.

May have built his job in this country up a bit while courting overseas.

Deep roots in community but little success in producing for family or in the eyes of his parents.

Fewer obligations in the hospital than at home.

Start of a long history of poor adjustment to school, service, and work.

Jumped into two kinds of training which did not pay off, hasn't made careful, realistic choices.

Apparently hard working since each training arrangement lasted two years.

Either lacked information of counseling eligibility or desired independence in planning.

Early interest in mechanical work.

Counseling Developments

chanic's helper, and cleanup man in a garage. Postservice experience included work as a cat operator, truck driver, shovel operator, auto mechanic's helper, automotive partsman, village marshal, part-time bartender, plumber's helper, and laborer. In a period of eight years after service, he had three hospitalizations, four years of training, and at least nine different jobs. He liked his jobs operating road-construction machinery the best because "it was interesting work that paid a good salary."

While still in school, he did summer work on his grandfather's farm, janitor work, and helped in a garage evenings. In school he was president of his class as a freshman, played quarterback one year on the football team, and played on a county volleyball team. He says he left school because the family (six brothers and two sisters) needed his financial contribution. In school he liked algebra and manual training but disliked history and English and got low grades in these subjects. He feels he was an average student.

Three years of service experience included armored force basic training with a short service school course in gun repair but with actual work as a truck driver, motorcycle driver, and tank driver. He had eleven months overseas duty with about six months in a combat area. He describes his main duty as the repair of machine guns and small arms but actually spent little time at this. He enjoyed motorcycle driving the most because it gave

Possible Implications

Appears to have worked at whatever was available.

Employment record reflects partly a lack of good total adjustment but also reflects the reality of the employment market in very small communities.

Seems to have liked jobs that allowed some independence.

Evening garage work and school subject preferences indicate mechanical interests.

Able to achieve social popularity without effort to succeed academically.

In large family probably got little guidance at home.

Pride—unwilling to admit he did a poor job in school; possibly happy to quit school.

Pride again—desire to have real skill; builds up what was really quite ordinary service experience for World War II.

Desire to be independent.

Inability again to adjust to authority or to social institutions, like school and service.

Admission of trials in service indicates some acceptance of the counselor.

Counseling Developments

him "more driving freedom." He had two minor courts-martial for "arguing with an officer" and "piling up a motorcycle." His highest rank in service was technical corporal (T/5).

At the time of first counseling the veteran was leader of his local service organization. He goes to an occasional dance and likes to play cards. He likes hunting but is no longer active in sports. He says he reads quite a bit but limits himself to outdoor and western magazines. He was not very well informed on current events. In his spare time he likes most to tinker with and repair farm machinery.

In addition to stating a preference for truck driving, the patient expressed a desire to operate a farm of his own. He would like very much to work independently even though he stresses the fact that he can get along well with others. He created a favorable first impression, meeting strangers without difficulty, talking easily (although with poor diction and occasional poor grammar). Physical appearance is good. He is of average height, weighs 170 lbs., and appears neat and well groomed.

Tests given during the first series of counseling interviews indicated well above average general mental ability as indicated by an Army General Classification Test score at the 98th percentile for World War II army inductees, with completion of the test in thirty-three minutes. This score held up at the 93d percentile for the AGCT college freshman norm group. Ability

Possible Implications

Ability to achieve socially in the community, again without having to utilize his abilities to be a productive member of the group—similar to the school experience. May be a reason why he apparently hasn't thought it necessary to really face his disability.

More evidence of mechanical interests.

Desire for independence.

Not facing disability.

Adjusts easily in social situations.

Weak in English and probably vocabulary.

Indication of higher level general mental ability than was anticipated.

Later developments indicated use of AGCT college norm group was not advisable; it may have influenced later decisions, even though he knew he was weak academically.

Counseling Developments

to understand mechanical principles as measured by the Bennett Mechanical Comprehension Test (AA) was at the 92d percentile for candidates for apprenticeship training. Ability to visualize spatial relationships was at the 88th percentile for World War II males, as measured by the Minnesota Paper Form Board Test (MA). Scores on the numbers and names sections of the Minnesota Clerical Test were at the 62d and 39th percentiles, respectively, for employed men and would be quite low were he to be compared with employed clerical workers.

On the Kuder Preference Record (BB) the patient scored at the 84th percentile in the mechanical area, the 73d percentile in the artistic area, and the 75th percentile in the social service area. There were low scores in the computational, clerical, scientific, and literary areas, with the remaining areas at about the 50th percentile. There was not time to administer the Strong Vocational Interest Test or a measure of personality adjustment. The patient also took the High School General Educational Development tests, passed them with standard scores averaging around 50, and has been issued a high school equivalence certificate. At the time of this testing Kuder Form C was not available at the counseling service.

The patient was very pleased with his test results, particularly those relating to general mental ability. He was not surprised at the interest test results, although he could not account for the artistic score and was somewhat disap-

Possible Implications

Early interests in mechanical things have a real basis in ability and aptitude.

Interest test results tend to bear out expressed and early demonstrated mechanical interests.

Use of High School GED's gave the patient some of the feeling of achievement he seemed to be seeking and also made him better qualified for more kinds of employment.

Reactions to both the interest test and the AGCT college norm comparison may indicate sensitiveness about the amount of education he has had.

Counseling Developments

pointed in his score in the scientific area. He said that he had once thought of college, although he had indicated before testing that had service not interrupted his planning he "might well have become a farmer."

After further evaluation interviews, the patient expressed interest in lighter mechanical types of work and stated that both he and his wife desired to move to the city. After studying occupational information and further discussion, he decided he would like placement in such jobs as automotive partsman, bench repairman, or assembler. He thought he also would like radio and television repair work but felt that he could not afford to take additional training at that time. Arrangements were made to have the veteran meet the veterans' employment representative at the state employment service. The representative was favorably impressed with the patient and felt there were good chances for his placement. The patient was to contact the employment service when he was ready to move. Follow-up revealed that the patient never made further contact for placement assistance.

Almost two years later, during the fourth hospital admission for diabetes mellitus, the patient was again referred by the ward physician, this time with indications that he had a particularly brittle type of diabetes which was difficult to control and that he would have to seriously consider job change. The patient had resumed heavy and irregular work, operating and repair-

Possible Implications

Patient is beginning to admit he is the one who feels he has to leave his community. Unfortunately, he was ready for discharge and did not have time to develop these feelings fully. Desire to move to the city turned out to be insincere.

Though the patient seemed to be sincere, he had not yet really accepted the results of counseling and apparently was just closing off the relationship in an agreeable and socially acceptable fashion. The patient showed signs of progress but apparently the situation required that the process move faster than he was ready to move.

Lack of acceptance of his physical condition, and the hard reality of the patient's local job market. The former was probably most important, since no effort was made to contact the counselor or the employment service.

Counseling Developments

ing road-construction machinery. During off seasons the family had received relief assistance.

The patient was seen again and seemed fairly cheerful. He paid token attention to the seriousness of his disability and indicated that he had not had time enough to follow up on job placement. He had felt he would give work in his home community another try before changing jobs or communities (this after three previous experiences ending in hospitalization). He said that local social agency officials had asked him to work out a possible training situation with the state vocational rehabilitation division, and he had expressed the desire to them to attend the university. He felt he would major in either engineering or education. The patient indicated that all he wanted the counselor to do was to help him decide in which of these two areas to major and to complete the section of the college application blank normally filled out by the high school, since the counselor had assisted in the process of earning the high school equivalence certificate. He expressed the idea that a person really ought to have a college education to get ahead in the world. This represented the depth of his thinking about college. He also pointed out that this would allow his wife to live in the city. We agreed to help him with his planning and accepted the application blank, with the suggestion it be filled out when he was sure of his choice of majors.

A check with the state rehabilitation counselor indicated that the state was

Possible Implications

Going through the motions of counseling again; little difference than when first seen.

No consideration of feasibility of training or employment prospects after training.

Doing the socially accepted thing.

Earlier Kuder and AGCT results probably influenced this desire for college.

Counseling conceived as a mechanical procedure requiring little participation by him.

General feeling of need to achieve. Why does the patient feel such a need to achieve? Perhaps expression of inability to achieve in his own community.

Pointing out directly at this point that college would be difficult for him might have terminated a counseling relationship which he had not yet fully accepted.

Need for co-ordinating counseling efforts with other

Counseling Developments

willing to pay for his training. They were not at all certain that college was best, but since he had high general ability and appeared very sincere, they did not feel justified in opposing his choice directly. On learning of the additional data in his hospital counseling record, it was agreed that we would try to make certain the patient made a good vocational choice and that the state would finance it if training seemed in order.

The patient agreed that a college aptitude test would be in order, since he would be competing at this academic level and might be able to work at improvement in any areas of weakness while he was still hospitalized. He also felt another interest test might help in choosing a college major but put off the idea of a personality test. On the Ohio State University Psychological Test the patient received a total standard score of 43, when compared to University of Minnesota entering freshmen, and part standard scores of 41, 46, and 46 on vocabulary, analogies, and reading comprehension, respectively. On the Strong Vocational Interest Test there were no primary patterns, but there was a strong secondary pattern in the Group IV occupations. His scores for engineer and in the physical sciences were in the *B—* and *C+* area.

The patient was disturbed by the implications of these test scores and the fact that they substantiated the results of tests given two years earlier. He held on to his desire to go to college, however, and was not told directly that he

Possible Implications

agencies and checking between agencies on whether or not counselees are known to them.

Good co-operative relationship with outside agency.

Perhaps the first real acceptance of his role in the counseling process.

Probably acutely aware of his lack of satisfactory school, service, and community adjustment; fear of what a personality test might show. It was not felt important to force the issue, since there were already many indications of inadequate adjustment, and the counseling relationship was now getting started on a good footing.

Additional test results bear out earlier tests and the implications of school and employment data.

Need to achieve at a higher level is still great. This is good, since we will want to try to make use of this motivation.

A way in which to help a pa-

Counseling Developments

might have trouble. Since the vocabulary score on the Ohio test was so low, it was suggested that he might want to try to do some vocabulary building with the educational therapy officer. He liked this idea very much and felt that he could improve a good deal, even in the month before college would start. He was referred with the educational therapist aware of the fact that we did not actually expect great improvement in such a short time and were more interested in the patient's experiences in the vocational planning process. If he did make progress, however, building his vocabulary would be helpful to him on whatever occupational level we eventually agreed upon.

The patient also resumed work in occupational therapy more or less on a hobby basis. The counselor was interested in this, however, as a source of data on dexterities and ability to work with small tools. He was reported to be good in both on leather work projects. He also seemed to be friendly and ambitious in OT.

The social service worker was also contacted. He felt that the veteran was not a very sincere person and did not take good care of himself physically. His following of his diet was also questioned, and it was suggested that perhaps the patient hadn't tried too hard to make a job change.

The patient returned after a few days of vocabulary building with the report that it was difficult work for him. He obviously was not happy with

Possible Implications

tient discover some of his weaknesses himself—less traumatic in this case.

Good personal as well as formal relationships between the counselor and hospital therapists are essential.

A way to get informal data on dexterities when the patient is fixated on an occupational level which doesn't make testing for them seem to be a logical part of counseling. Further confirmation that the patient seems to work hard when on a job.

Diet is a point to be checked with these patients, since if it isn't followed, vocational planning won't do much good.

Patient begins to get some insight into the unrealistic nature of his choice of college work. Probably important to

Counseling Developments

his word lists and his thesaurus. He was urged to work hard at it and also was given university bulletins for education and engineering to look over, so that he would be better informed when we were ready to discuss a choice of college major. In about two days the patient was back, indicating that the college kind of course seemed a little long for a man of his age to start. He wasn't sure it would be fair to his family. He asked for some trade school bulletins to study, and he stopped going to educational therapy. On his next visit he wondered whether or not he might be able to get some training in radio and television repair work. At this stage the counselor agreed that perhaps he would be a little older than some of the college students and that school at that level might be a little difficult for him after all these years and with only two years of formal high school work. He was given descriptive material on radio and television repair work and trade school bulletins to study. It was also suggested that he visit some trade schools while on pass from the hospital, and this was arranged with the ward physician.

After visits to schools and referral back to educational therapy for a trial course in the fundamentals of electrical theory, the patient decided that television repair was what he really wanted. He picked a school that does not have general subjects classes which might give him academic difficulty. He felt that after training he would like to work in the vicinity of his local community and began to realize that

Possible Implications

let the patient go at his own speed here if possible.

Too much pride to admit he was wrong. Finds a socially acceptable way to start backing away from the college idea.

Counselor felt the patient progress indicated active participation and now an honest desire to hear the counselor's opinions.

Allows patient to see the actual work and the training environment before final decisions on a training plan are made.

Course progress helped to evaluate sincerity of the patient. Use of educational therapy for prevocational evaluation and training. Also serves to give the patient a head start on some of his younger competitors who have no disability problems. Gives feelings of assurance.

Need to cite family desires

Counseling Developments

he would probably have even greater financial problems if he attempted an early move of his family to the city. It developed that he really liked his home area but for several years had had to be dependent upon the community for support assistance, even though he looks able-bodied and can participate in local civil activities with success.

Since several services had been working with this patient it was suggested by the counselor that patient's problems should be staffed by the hospital rehabilitation board. It was hoped that by co-ordinated effort personal, physical, social, and occupational adjustment might be achieved for the patient's own benefit and also so that he would not be likely to return a fifth time for the same reasons to occupy valuable bed space. After thorough board discussion, the following things were achieved:

The patient's wife was seen by the social worker, and it was established that patient has been getting an adequate diet. It was also learned that she was not anxious to leave her community to live in a larger city.

The patient definitely decided to go to a trade school to learn radio and television repair. His wife was willing to have him take this training in the city if arrangements could be made for him to come home weekends. Training closer to home was unavailable.

The ward physician felt that his choice of work, if done on a regular

Possible Implications

to cover his own personal desires is disappearing—may indicate increased ability to deal with his own problems.

Example of hospital team effort. An economical way for all services to share and gain information. Also co-ordinates the approach all services will take in handling patient problems and requests. The counselor can initiate this team approach.

Diet problem not a factor. Adjustment with wife good. Quoting wife's desires *was* expression of patient's own desires.

Patient back to job area of first counseling. This time his decision should be more sincere since he has worked hard on planning it.

Maintaining control of the diabetes should be possible in

Counseling Developments

basis, would be compatible with his disability. Certainly it would be a great improvement over his sporadic, heavy construction work.

It was agreed that the state rehabilitation counselor's concern over placement after training should be investigated. After determining from the VA regional office training officers that there was considerable television in the area and only a few repair facilities, the patient, while on pass, visited repairmen in the area and got the promise of two men that they could use his services now were he trained and would consider him after training if they were still in the area.

The educational therapist continued with the course in electrical theory and felt that the patient was interested and able to progress satisfactorily.

The social worker co-ordinated work with local agencies so that the veteran received residence and meals at the Y.M.C.A. and money for noon meals at the school. The county service officer arranged for bus transportation home and back each week end, and the local welfare agency is supporting the family at home while the patient is in school. Part-time work while a student was not felt desirable in this instance because of the necessity for very regular energy output.

On request, the patient checked possibilities of obtaining his diet within his money allowance at both the

Possible Implications

the training and job chosen by the patient.

Seriousness of the training decision is re-emphasized by having the patient participate in investigating future employment possibilities.

Further indication of adequate motivation and necessary aptitude.

Financial needs seem to be met completely enough so that heavy week-end work will not be as necessary or tempting to the patient.

Done to re-emphasize to the patient the need to take his physical condition seriously.

Counseling Developments

Possible Implications

Y.M.C.A. and the school before the program was finally approved.

The physician talked with the patient about future disabilities that might result from repeated exacerbations of his disease.

The state rehabilitation division is financing the veteran's training.

The patient has been seen once after about two months of school training. He appears to be happy in his situation and reports he is doing satisfactory work. From the standpoints of disability, measured abilities and interests, experience, hobbies, and expressed desires, he appears to have made a realistic choice for which he has good chances for success. Perhaps the biggest question remaining is whether or not he will find enough activity, interest, and pride in this new skill to compensate for the more thrilling but incompatible activities he preferred up until his last hospitalization.

The patient was seen again after approximately nine months of school training. He was making good academic progress and appeared to be satisfied with his vocational choice.

Done because in the past he had not seemed impressed by his physical problem.

Good agency co-operation.

Apparent adjustment to the new training situation. This still does not assure success, since he successfully went through two training periods in the past without making an adequate job adjustment.

Continuous follow-up is very desirable here to catch quickly any factors that might threaten the total rehabilitation plan.

Name Patient A
PLEASE PRINT (LAST) (FIRST) (MIDDLE)

Date of Test _____

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ADULT PROFILE SHEET

• FOR MEN •

For Form BB of the

KUDER PREFERENCE RECORD

Vocational

(Profile for Women on reverse side)

DIRECTIONS

Follow the directions below carefully:

1. Check to see whether all questions were answered. Then detach the answer pad from the test booklet by lifting the pad upward from the binding. ☐
2. Turn the answer pad over to the last page which is marked with the figure 1. Count the number of circles in which holes are punched, starting at the arrow. Do not count the cases in which there are three punches in a circle, since these punches represent errors. In the space for score 1 on the cover of the answer pad record the number of holes you have counted. ☐
3. Follow the same procedure for each of the other scores. Note that scores 2 and 3 are obtained from the same page, and that scores 6 and 7 also come from one page. ☐
4. Obtain the count again for each score, recording your answers in the spaces provided on each page, and compare these scores with those entered on the cover. In cases of differences, make the counts over again until you are sure the scores are right. ☐
5. Enter the nine scores in the space provided at the top of the chart on this page. Men should use the chart at the right; women should use the chart on the reverse side of this sheet. ☐
6. Find the number in column 1 which is the same as the score entered at the top of the column, and draw a line across the column at that point. Do this for each column. If a score is larger than any number in the column, draw the line across the top of the column; if it is smaller, draw the line across the bottom of the column. ☐
7. Fill in the entire space between the lines drawn across each column and the bottom of the chart. The result is the "profile" for this test. The examiner's manual contains suggestions for interpretation. ☐

JOB SUGGESTIONS for MAJOR INTEREST AREAS:

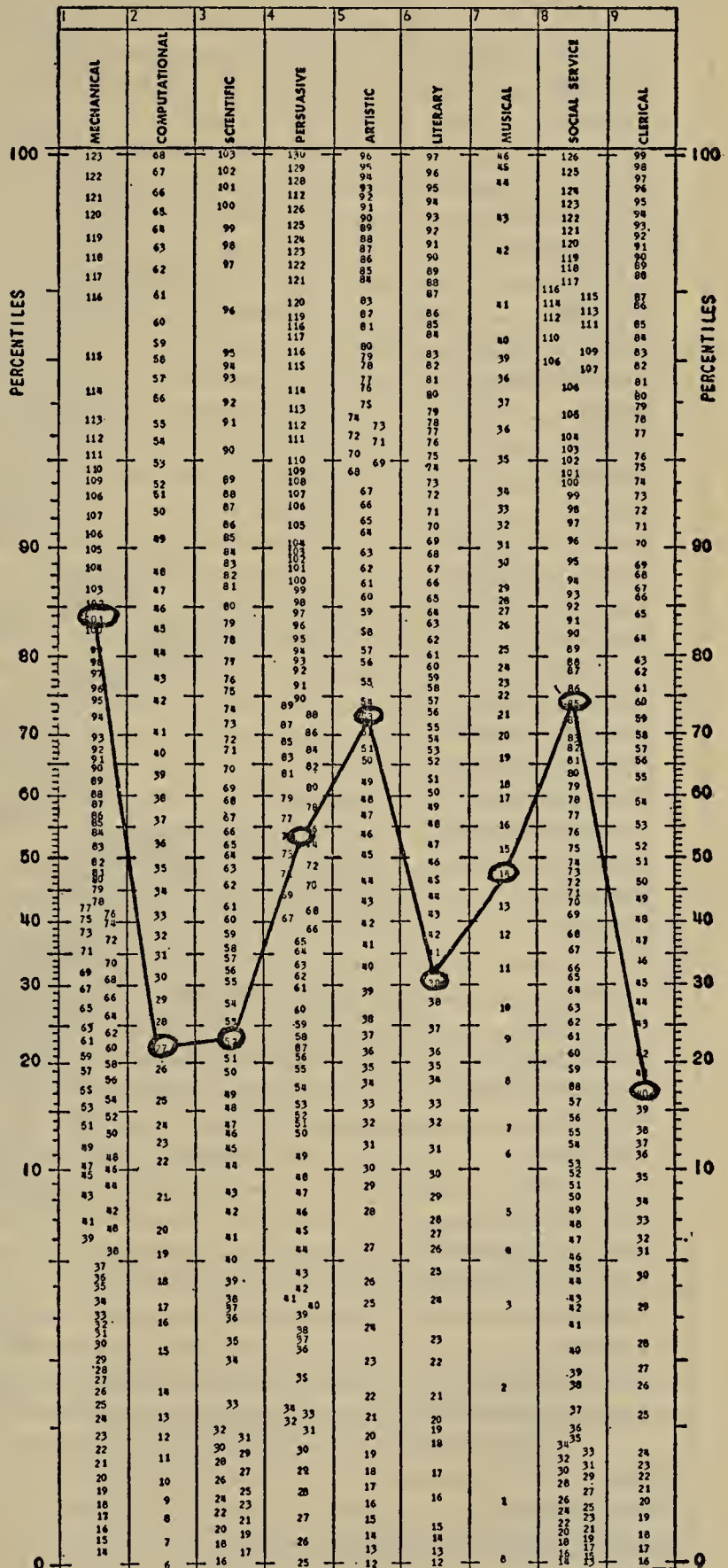
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Published by

SCIENCE RESEARCH ASSOCIATES

228 S. Wabash Avenue Chicago 4, Illinois

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STRONG VOCATIONAL INTEREST TEST—MEN

GROUP	OCCUPATION	0	10	20	30	40	50	60	70	
STANDARD SCALE										
I	ARTIST									
	PSYCHOLOGIST (REV.)									
	ARCHITECT									
	PHYSICIAN									
	OSTEOPATH									
	DENTIST									
	VETERINARIAN									
II	MATHEMATICIAN									
	PHYSICIST									
	ENGINEER									
	CHEMIST									
III	PRODUCTION MANAGER									
IV	FARMER									
	AVIATOR									
	CARPENTER									
	PRINTER									
	MATH. PHYS. SCI. TEACHER									
	IND. ARTS TEACHER									
	VOC. AGRICULT. TEACHER									
	POLICEMAN									
	FOREST SERVICE MAN									
V	Y.M.C.A. PHYS. DIRECTOR									
	PERSONNEL DIRECTOR									
	PUBLIC ADMINISTRATOR									
	Y.M.C.A. SECRETARY									
	SOC. SCI. H.S. TEACHER									
	CITY SCHOOL SUPT.									
	MINISTER									
VI	MUSICIAN									
VII	C.P.A.									
VIII	SENIOR C.P.A.									
	ACCOUNTANT									
	OFFICE MAN									
	PURCHASING AGENT									
	BANKER									
	MORTICIAN									
	PHARMACIST									
IX	SALES MANAGER									
	REAL ESTATE SALESMAN									
	LIFE INSURANCE SALESMAN									
X	ADVERTISING MAN									
	LAWYER									
	AUTHOR—JOURNALIST									
XI	PRESIDENT—MFG. CONCERN									
STANDARD SCALE		20	30	40	50	60	70			
INTEREST MATURITY										
OCCUPATIONAL LEVEL										
MASCULINITY—FEMININITY										

Patient A Test Results

<i>Test</i>	<i>Norm Group</i>	<i>Raw Score</i>	<i>T or S Score</i>	<i>%ile</i>
AGCT (AH)	WW II army induc-			
	tees	119	136	98
AGCT (AH)	College freshmen	119	136	93
Ohio State University				
Psychol. Test (21)	College freshmen	64	43	25
Test 1	" "	11	41	18
Test 2	" "	23	44	27
Test 3	" "	30	46	34
Bennett Mech. Comp. (AA)	Candidates for ap-			
	prentice tng.	49	64	92
Minn. Paper Form Board				
(MA)	WW II males	44	54	66
Minn. Clerical Test—Nos.	Employed men	94	54	66
Minn. Clerical Test—Names	" "	70	47	40
Minn. Clerical Test—Nos.	Male clerks	94	36	8
Minn. Clerical Test—Names	" "	70	34	5

The following is a summary of agencies and specialists involved in planning with the patient:

In the Hospital

<i>Agency or Service</i>	<i>Specialist</i>
Medical service	Ward physician
Vocational counseling service	Vocational counselor
Social service	Medical social worker
Physical medicine and rehabilitation service	Educational therapist
	Occupational therapist
Hospital rehabilitation board	Physical therapist and nurse (in addition to specialists already listed)
	Physiatrist
Dietetic service	Dietician

Outside the Hospital

State employment service	Veterans' employment representative
State division of vocational rehabilitation	Rehabilitation counselor
	Medical consultant
Two trade schools	School representatives
Y.M.C.A.	Housing official
	Dietician
Veterans' Administration regional office	Training specialist
County	County service officer
	County welfare worker
Private industry	Two potential employers
Immediate family	Wife

SUMMARY

Literature pertinent to vocational counseling with diabetic patients has been cited, and an attempt has been made to give the vocational counselor some medical background and some sample questions to be resolved with the ward physician. Some of the considerations the vocational counselor may find useful are summarized as follows:

1. A diabetic practicing good medical and personal care can do many jobs successfully.

2. The diabetic patient is generally well informed about his medical condition.

3. Planning for constant daily energy output in a job is ordinarily more important to maintaining control of the diabetes than is the heaviness of tasks involved in particular jobs.

4. There may be differences in interest and motivation during periods when insulin dosages are being varied in the treatment program. It may be desirable to postpone testing of patients until insulin dosage is well established.

5. Thorough development of past work history and activities would appear to be desirable to assist evaluating both the factors leading to present breakdown and the possibilities of capitalizing on past experience in job planning.

6. There appears to be little evidence that there are differences in intelligence between diabetics and the general population.

7. Since there has been some case history evidence presented that might point to the importance of emotional factors in the incidence of diabetes, the vocational counselor should be alert to possible need for referral for psychotherapy and should consider the avoidance of emotional trauma in planning for the future with the patient. The counselor should not forget that a real physical disability exists, however.

8. In posthospital planning with the diabetic patient careful attention should be given to details such as diet, insulin supply, wife's understanding of the condition, and the realities of the labor market in the patient's community, in addition to vocational factors, such as abilities, interests, personality characteristics, and job-placement plans.

A case history was included to illustrate some of the vocational counselor's problems and activities in working with a diabetic patient.

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11

The Amputee

PROBLEMS PRESENTED BY THE CONDITION

In a general medical and surgical hospital, the vocational counselor will quite frequently be asked to participate in the rehabilitation of patients with amputations. If he is to be effective in his contribution to the patient and the team, he should have considered the incidence of amputations, the experience of experts with amputees, the problems amputation brings to the patient, and the counselor's place in the hospital procedure with this kind of patient.

In Kessler's study (82, p. 503) we learn that in the four years of World War II experience, "approximately 18,000 American servicemen lost limbs as a result of war wounds and operational injuries. During this same period 120,000 American civilians lost limbs as a result of accidental injuries." Adding to this the injuries of the Korean conflict, the ever increasing accidental toll in industry, the fact that some amputees need further hospitalization for stump injuries, revisions, and other medical conditions sometimes necessitating amputation, it becomes obvious that amputations represent a disability category with which counselors will be very active. Thomas and Haddan (133, p. 284) estimate conservatively "that there are at least 40,000 major amputations performed each year in the United States which require prostheses."

Rehabilitation of the amputee begins early in the period of hospitalization. As Kessler (82, p. 517) states, it is "not a

disorganized, fragmentary type of treatment but an integrated concept of medical care that sees the patient through from injury to employment." On the basis of extensive service and civilian experience, he emphasizes (82, p. 503) that full restoration of the patient requires an integrated treatment plan where the surgeon, limb maker, physical therapist, and all ancillary workers preparing the patient for gainful employment have a combined responsibility. He feels that the rehabilitation of the amputee includes five major steps (82, p. 504):

1. Psychologic preparation.
2. Adequate surgery.
3. Aftercare of the stump.
4. Selection, fabrication, and fitting of the prosthesis.
5. Training of the amputee.

The vocational counselor's contributions will be most obvious in the first and last of these five stages, although he will be active with the patient throughout the period of hospitalization. Even though he will not participate directly in such a process as aftercare of the stump, except possibly in assisting in proper patient motivation, he should have some idea of what the patient is experiencing. At this stage, too, he can gain much information on patient reactions, co-operation, plans, and motivation to get well from the physical therapist. Although the counselor's participation in amputation cases will bring him into contact with many people, in and out of the hospital, he will be most active with the ward physician, the physiatrist, the physical medicine therapists, and the social worker.

To better understand the relationships between the orthopedic surgeons and the physiatrist, the counselor should realize that physical medicine is a relatively new specialty. Shands (117, p. 699), in a presidential address to the American Orthopaedic Association in 1954, pointed out that the pre-World War II medical and surgical aftercare programs of many orthopedic surgeons were inadequate and that the

union of physicians and physical therapy practitioners has resulted in broader rehabilitation services which have shown the public "the tangible benefits to patients and budgets of good rehabilitation programs—of what might be called the postwar concept. . . . How futile would be all of our treatment, particularly our surgery, without proper aftercare, and how dependent we are on effective rehabilitation for our patients." He appealed to all orthopedic surgeons to be more aware of the need for total rehabilitation services and stated further that "Wiles has rightly said that reconstructive surgery should never be attempted unless good facilities are available for rehabilitation and that these should be under the full control of the surgeons."

The vocational counselor will probably function most effectively if he considers the ward physician as having final responsibility for the medical and surgical care of the patient, and the physiatrist as the person co-ordinating the team effort, within this responsibility, for physical reconditioning, training, and ultimate return to a productive place in community life.

MEDICAL INFORMATION FOR THE COUNSELOR

Psychological preparation of the patient before amputation is desirable whenever possible. Thomas and Haddan (133, p. 257) emphasize this:

The amputation of a limb is nearly always accompanied by considerable emotional shock, usually evident in the form of an overwhelming sense of loss with resultant despondency of varying degree. In some cases this reaction is profound, particularly if the amputee is of an unstable emotional makeup, and it offers a formidable problem difficult to combat. It is particularly likely to be experienced by persons previously healthy and active in whom amputation is suddenly necessitated as a life-saving measure by a severe unexpected trauma or acute disease.

They also pointed out that if the patient has had time to prepare for the ordeal, or the amputation is done to remove an unsightly or useless limb, the shock is not so great. "The

depression is also likely to be more severe if the loss is of an upper extremity." Those familiar with amputees (for example, 133, 50) stress the necessity for building up positive attitudes. Preparation for amputation will be influenced considerably by those attending the patient, including the counselor. The counselor can help in personality evaluation and in conveying to other team members his appraisal of the patient's acceptance or rejection of the treatment planned for him. Unless the patient is acutely ill, the gathering of evaluative data for use in planning future placement will already have started. Positive planning is likely to be much more effective at this stage than actively feeling sorry for the patient. At the same time, the patient's feelings must not be ignored. He may wish to talk about the ordeal he faces, and the counselor must be careful not to dismiss him lightly as just another patient for surgery.

Different types of surgery for amputations are described in a fairly nontechnical fashion by Kessler (82 and 85). Although the counselor has no responsibility in this area, he should be familiar with the extent of the surgery involved and the kinds of operations done, so that he will have some idea of what the orthopedic surgeon and the physiatrist may later be describing to the rehabilitation team.

The vocational counselor will also be able to converse more intelligently with the patient, the doctor, and the physical therapist if he is aware of all the attention and effort that is directed to aftercare of the stump and the general reconditioning of the patient. Attention is given to stump shrinkage, stump conditioning, the correction and prevention of contractures, the adequacy and possible revision of the stump, circulatory problems, stump ulcers, dermatitis, skin grafting, and similar problems. Other medical conditions, such as diabetes, not under adequate control, may further complicate matters. Exercise of muscles controlling the stump and exercise of the whole body to improve balance and general control may be undertaken.

In the case of bilateral above-the-knee amputees, exercise of the abdominal muscles may be included in the treatment plan. References in the bibliography, such as those of Kessler (82, 83, and 84), will help the counselor to learn more about these activities to which his patient is devoting a good deal of time and energy. The patient will often be proud of his reconditioning achievements and will expect the counselor to understand what he's talking about.

The counselor will be interested also in the processes of selection, fabrication, and fitting of the prosthesis. He will be concerned not only with what the patient is able to do with the prosthesis, but with how well the particular prosthesis will adapt to the patient's plans and desires. The study by Thomas and Haddon (133) provides a good foundation on the kinds and uses of prostheses. One reference (145, p. 56), for example, points out that many upper-extremity prostheses that look like the human arm and hand have relatively little functional power. The amount of tension in a gripping device on an upper-arm prosthesis may have much significance for the kind of work being planned with the patient. Such practical matters as having proper dress or work shoes on the leg prosthesis concern the counselor and the patient in their posthospital work planning. Valuable experience can be gained by the counselor by attending walking or orthopedic clinics where the ward physician, orthopedic consultant, limb maker, and physical therapist evaluate the effectiveness of the fitting, the appliance, and the amputee's efforts and progress. Both the difficulties and the possibilities of the double-leg amputee just getting to know his prosthesis need to be seen in just such a clinic situation to be really appreciated. If the counselor can become part of the clinic team in his hospital and attends regularly, he can see at firsthand the progress of his patient in adjusting to and learning to use a prosthesis. He can also indicate to the other professional staff just what the patient hopes to get out of the prosthesis in the job situation. Moreover, he

may find better acceptance of counseling on the patient's part when it is known that the counselor even attends what patients like to call the "leg show."

Kessler (85, p. 124) says that for high upper-arm or shoulder amputations, less emphasis is placed on functional value of the prosthesis and more on the development of skill and dexterity of the remaining unimpaired parts. It should be emphasized here that fitting is just one part of the rehabilitation process. In past years, for many patients, treatment stopped at this point. Now, "fitting is the beginning rather than the end of the road of the patient's adjustment to his prosthesis. Training and instruction are paramount" (83, p. 180).

Training in the use of the prosthesis is a very important process, and the vocational counselor should become involved in it. Deaver and Brown (48, p. 3) emphasize that the orthopedically exceptional need to learn the elementary demands of locomotion, self-care, and the use of the hands before vocational placement in any self-supporting position is likely. They also provide a useful scale (primarily for the physical therapist but of interest to the counselor) for rating progress in such activities. Thomas and Haddan (133, p. 263) feel that "rehabilitation of the amputee must begin with instruction and training in the use of the prosthesis, and until this phase of his rehabilitation is successfully completed other programs of rehabilitation should be postponed." We would agree with the stress placed on learning the use of the prosthesis in locomotion and self-care but would disagree that other activities should be postponed. Instead, as Kessler (85, p. 234) says, the amputee "needs a prosthetic appliance to compensate for the lost limb, but he also needs to overcome anxiety about his future." The same author feels that "an important opportunity is missed if the lengthy convalescence is not utilized to improve the patient's vocational status when he is discharged" (85, p. 239). In another reference (83, p. 178), early planning for

the future by the social worker and the rehabilitation officer is stressed by Kessler. "If for various reasons, this service cannot be rendered before the operation, it should be done as soon afterward as the patient's condition will permit." The counselor is seen as a person active with the patient throughout his hospitalization and after his discharge. The vocational counselor can help give direction to some of the occupational and educational therapy activities, which will probably run concurrently with learning to use the prosthesis, so that they will run in channels that will be both informative and productive in terms of future vocational activity. Full acceptance of counseling and good vocational planning progress are likely also to result in better motivation and energy output in learning effective use of the prosthesis. Kessler (86, p. 262), with reference to navy experience, points out that work training (such as occupational therapy, educational therapy, or manual arts therapy) provided the amputees with a laboratory in which they could test out their vocational interests. Training and vocational exploration during the period of hospitalization should facilitate or supplement the amputee's training or experience and make his adjustment after hospitalization easier.

Denning *et al.* (51) have written a manual for disabled and paralyzed persons, and for therapists, that will also help the counselor to understand such things as crutch walking, the problems of double amputees in learning to use a prosthesis, or the problems of single amputees learning to use a pylon. Reading through this book will give the counselor a better appreciation of the patient and staff effort involved in teaching patients to walk.

During the training period, the vocational counselor will also want to learn about such matters as how far the patient can walk, whether steps are mastered well, and when bus or car travel is possible, so he can know when to send the patient out to start making employment contacts. Passes for

patients to make such contacts can easily be arranged for with the ward physician. It is best to avoid a period of post-hospitalization inactivity and to start placement efforts while the patient is still in the hospital. This will help to keep the patient from feeling that he is different and unwanted during the period the placement officer needs to make employer contacts. It would seem desirable to give these patients some responsibility for personally going out to meet placement men and prospective employers. Authorities (for example, 133, p. 258) feel that during the convalescent period these patients should be encouraged to do things themselves in order to build up independence. In modern hospitals amputees are ordinarily kept very busy; there is little time allowed for brooding and self-pity.

It is also valuable to keep amputation patients near each other so that competition and emulation are fostered. Under these conditions, morale is more likely to be high. If the counselor is working with a rather solitary and depressed patient, he might consider having the patient come over to the service at a time when other more disabled but better-adjusted patients are present. Sometimes it is also possible to arrange for small group meetings, ostensibly on legal eligibilities for training or some other neutral subject, so that depressed patients can hear the reactions and enthusiasm of those who are better adjusted.

QUESTIONS TO BE RESOLVED WITH THE PHYSICIAN

Each patient, of course, has his own kind and site of amputation and his individual reaction to it. The counselor may wish to consult with the ward physician on such points as the following:

With this patient, how effective will a prosthesis be in terms of the site and kind of amputation?

From the patient's behavior on the ward, does he seem to

have accepted his loss? Is he enthusiastic about the possibilities of the prosthesis? The physical therapist and the ward nurse can also contribute here.

If the amputation was the result of severe burns, is the stump area weaker because of skin grafts, and will it be more likely to break down with normal use of a prosthesis, than would be the case for most amputees?

If the amputation was below the knee, does the patient have normal function and weight-bearing capacity in the knee, or does it offer additional job-placement limitations?

In the case of a double amputation above the knees, does the patient really seem to have enough motivation and physical ability to use the necessary prosthesis? Or is it likely that he will discard it after leaving the hospital and should realistically be treated as a wheelchair patient as far as vocational planning is concerned?

If the patient has a prosthesis and doesn't wear it, is this most likely because of improper or incomplete training in the use of it, actual physical discomfort from it, a rejection of it because of nonacceptance of his physical status, a desire to draw the attention of others to his condition, or some other reason?

Are there any medical conditions, such as diabetes or poor circulation, to be considered in estimating effectiveness in the use of a prosthesis and durability of the stump?

Is weight likely to be a disturbing factor as this patient grows older?

If the patient will have a long hospitalization, can a fairly accurate estimate of ultimate capacities be made now so that the patient can turn free time into productive educational, occupational, or physical therapy directed toward employment areas likely to be finally selected?

COUNSELING CONSIDERATIONS

It is important to evaluate carefully how well the patient has accepted his status as an amputee. Dembo *et al.* (50, pp.

80, 81) emphasize that the amputee feels not only a physical but a psychological loss, and the meaning of this loss determines to a large extent how well the person will adjust to his new physical state. "The injured feels the loss of status as a 'normal being' in the devaluative attitude of the 'fortunate' to the 'unfortunate.' " He may also devalue himself because of his own previous attitudes toward the disabled. He may also feel "that he is not accepted by groups as equally worthy." These writers point out that acceptance of loss does not mean becoming reconciled to the condition. Instead they stress that acceptance of loss means "overcoming the feeling that one is an unfortunate person—a process of value change."

The amputee, in denying that a difference exists, may actually create more difficulties for himself by not accepting the physical help or sympathy in time of stress that non-injured people normally accept (50, p. 85). When the amputee is able to realize that he has many abilities left—more than he will use—and that the emphasis is on ability rather than disability and unfortunateness, he may see himself as equal to, or even better than, many other persons. Counseling, aptitude testing, and prevocational tryout may go far in emphasizing to him how much ability he really has left. Not infrequently, he will discover that he has abilities he had not previously considered.

The conditions under which the amputee was injured may have a good deal to do with how well he accepts his new status. If he is unrealistic or belligerent, the counselor and social worker, working together, may be able to help the team by establishing whether or not this is a new reaction to his physical status. It may simply be a manifestation of his preamputation personality pattern. Or it may have to do with guilt feelings about his injury.

Family life and responsibilities are also important. What adjustments will the family require of him? How do they accept the amputation? Will they treat him as an unfortunate

invalid or help him to realize his remaining work potential? It is often valuable for the counselor to arrange, perhaps through the social worker or patient, for a meeting with the wife and the patient. This will give him an opportunity to make some estimate of how the home will affect future vocational adjustments.

It is important for the counselor to make early contact to assure the amputee, by presence and interest, that he can be a productive individual again. It is also important to put emphasis on the future to be planned rather than on the present predicament. This imposes limitations on the counselor's usual procedures, since the patient may well be a bed patient when first seen. Interviewing at this stage is probably best limited to superficial data, reserving areas that may develop more confidential information for the privacy of the counselor's office during later interviews. Testing may be started on the ward, if necessary, but probably should be limited to interest and personality tests where time limits and the avoidance of collaboration with other patients are not such important elements. If the bed status is fairly extended, the counselor may wish to drop in occasionally to chat with the patient, even though this may not seem at the moment to advance the actual counseling process. The counselor may not realize how much the presence of someone interested in ultimate vocational plans may actually mean to the patient's progress.

Physical capacities need careful evaluation. For the arm amputee, such things as need in the job for fingering, handling, feeling, pushing, pulling, reaching, carrying, lifting, and throwing must be evaluated in terms of patient capacity. For the leg amputee, such abilities as walking, jumping, running, standing, balancing, crawling, turning, stooping, and kneeling, are important. Each patient will have to be evaluated in terms of his own training, prosthesis, and personal adjustment. For lesser amputations, for example, of fingers, perhaps there is not too much limitation unless the thumb is lost (145, pp. 56-58).

The patient may have difficulty with phantom limb sensations. Kessler states that generally this image disappears in six to twelve months. He also states that "shock treatments in severe cases which are accompanied by pain have been reported to yield good results." If the phantom limb sensation or the lack of acceptance of loss has led to alcoholism or drug addiction, the counselor's problems are further complicated. He may wish to consult with the psychiatrist and clinical psychologist or enlist the services of the social worker and Alcoholics Anonymous workers in order to discuss possible suggestions with the ward physician.

At the end of the hospital vocational counseling process, the amputee can usually be placed more easily than many medical patients. If he has abilities and skills to sell, his obvious disability, because of its seemingly clear-cut nature, does not seem to impede employability. The trick seems to lie in arranging for the employer to witness how well the patient can handle himself with his prosthesis. Employer prejudice would seem to be mainly against amputees as a class regarded as cripples, rather than against the individual who demonstrates that he can perform the necessary physical movements for the job. The kind and the difficulty of the placement, of course, will depend upon the amputation, patient motivation to work, the counselor's skill in helping to formulate a plan, and the current labor market. Some idea of the range of jobs performed successfully by amputees—for example, machinist, farmer, teacher, camera technician, lens grinder—is given by Kessler (83, pp. 59–69). The amputee can do many things; but he has many problems and, at times, will provide a real challenge to the best of vocational counselors.

ILLUSTRATIVE CASE STUDY

The case study which follows is presented to illustrate some of the problems that may arise in vocational counseling with an amputee. The case was not selected as a representative one but rather to illustrate some of the decisions re-

quired by the counselor, such as whether or not the patient was really distressed by his condition; whether the amputation or the past adjustment history was the more important determinant of the patient's reactions; and whether or not the patient was accepting counseling and trying to contribute to the success of vocational planning.

Patient B: amputation, left leg; age, 23; modal prior occupation, projectionist.

Counseling Developments

This patient is a twenty-three-year-old, single, white veteran of three months in World War II. He has no service-connected disability and no eligibilities for training under laws administered by the Veterans' Administration. He was admitted to the hospital for treatment of compound fractures of both legs, incurred in an automobile accident. He was discharged from the service for arthritis and, at present, has a severe arthritic condition in his hips.

The patient has no dependents and lives in a small town with relatives. The parents are living but separated, and the patient has not lived with them since he was sixteen years of age. He has no brothers or sisters. The father is a bartender; the mother runs a rooming house. The patient left school after completion of the eighth grade. He was having physical difficulties then and spent over a month in the hospital with an arthritic condition.

The veteran was referred to the vocational counseling service by the social worker when he expressed a desire

Possible Implications

If training is considered, patient will need state help.

Even with good results in treatment of present condition patient will be limited orthopedically.

No responsibilities.

Poor family background.

Probably has had little or no family supervision or direction. Weak family ties.

Poor general education.

Possibly has never had to achieve much because of physical condition.

Does he sincerely desire assistance or is he doing the socially accepted thing?

Counseling Developments

to formulate some vocational plans. His work experience was very spotty. He had been unemployed for about four years. Prior to that time he worked for about two years as a projectionist in a small town. A summer was spent as a hoist operator in a canning factory.

The ward physician indicated that there was some doubt of saving the left leg. He also felt that with the advanced arthritic condition in the hips, in a relatively young person, there would be a need to engage in relatively sedentary work when the patient was discharged, even if the leg were saved.

When first seen on the ward, the patient was in traction and quite uncomfortable. He stated that he was interested in job planning and seemed rather confident of his abilities. He stated an interest in such occupations as bookkeeping, selling, and traveling of some sort. He seemed confident and sincere in his desire for help in vocational planning.

The patient was seen for a number of interviews on the ward. He stated that while in school he liked arithmetic and reading and disliked (and had trouble with) history. He felt he received rather good grades in all subjects, however. He reads a good deal now, preferring fiction and detective stories. Outside activities include target shooting, attending legion meetings, and watching dancing. Service experience was so brief that it included only basic training.

Possible Implications

Poorer employment record than disabilities at that time would account for. Little desire or need to achieve in jobs?

Likely to be very disabled.

General office or bench-type jobs probably should be considered.

Overconfident, immature, or covering up a feeling of depression over physical state? Seems rather confident for having never demonstrated ability in jobs or educational achievement. Selling and traveling suggest desire for activity.

Counselor somewhat limited by long stay of patient on the ward.

Confidence in his ability again. Or desire to present himself in a favorable light? Probably immature.

Dancing—desire for activity?

Service experience not useful.

Counseling Developments

Since the veteran was in traction for almost all of the first period of hospitalization (although in a private room), the testing that could be done was very limited. He took an interest test and scored very high in the computational and clerical areas. On a test of ability to understand mechanical principles he scored above average for beginning apprentices in the skilled trades and above average when compared to engineering freshmen. On the Minnesota Multiphasic Personality Inventory he received a high score on the Ma scale. Restlessness observed in interviews with him and occasional expressed desires to drive his car again at high speeds tend to go along with this score. He also indicated a desire to try the High School General Educational Development tests at some time when he was out of traction. Intelligence was estimated by the counselor to be just average.

Since he had expressed interest in business-detail work and had interest scores that were compatible with this interest, it was suggested that he try out some of this work while still a bed patient. He was referred to the educational therapist. He did fairly well in his bookkeeping, although he was not too reliable about completing lessons regularly, becoming alternately depressed about his bedridden situation and interested in other projects. He did a good deal of leather work with the occupational therapist, with rather good results on such things as billfolds and belts. He also did some knitting but was not too interested in it.

Possible Implications

Testing limited by physical condition. Tests requiring speed or concentration probably should not be used in this situation.

Measured and expressed interests agree.

Good understanding of mechanical principles but no interest in such things. Desire for activity again—a restless person. Might cause one to question real desire for business-detail work. Patient probably picked work usually thought of by very disabled persons.

No harm in trying prevocational work in bookkeeping. Good way to utilize resources of educational therapy.

Ability to do the work but some question of real interest in it.

Easily distracted from work more important to him in terms of occupational future.

Counseling Developments

The counselor indicated at this point that although the patient would need sedentary work when discharged, seemed to have expressed and measured interests in this area, appeared to have average general ability, and referral to educational therapy for tryout seemed indicated, he was not very mature about his occupational planning.

The course of vocational counseling with this patient extended over about two years. There were numerous leaves and periods when the patient was not feeling well physically during this total period. After about one year, the patient's left leg was amputated. This did not seem to be very traumatic to him, since he had requested that this be done some time before the actual amputation. This made it obvious that, with the added hip difficulties, the veteran should be considered a wheelchair patient on discharge from the hospital.

After numerous false starts, the patient came down to the service and took the High School GED tests. He passed them and received a high school equivalence certificate. He continued with his bookkeeping. Since it was felt that with his lack of specific skills and his disability he needed more than help on job placement, he was referred to the state vocational rehabilitation counselor for possible training in business skills. The veteran indicated that he wished to take such training, but it was still felt that he had not really accepted this plan, preferring something more active than bookkeeping. Further

Possible Implications

Counselor doubts real acceptance of counseling by the patient. This is no time to terminate the relationship, however, since acceptance and understanding may develop later.

Amputation not traumatic to patient. He may be accustomed to status of being disabled, may actually have depended upon it for some time.

Complicates placement problems when discharged.

Again, the patient has the necessary ability to achieve but is not very reliable. Question his actual interest in completing these tests.

Every assistance is offered the patient in learning a skill with which to support himself.

More evidence of lack of sincerity to formulate a realistic vocational plan.

Counseling Developments**Possible Implications**

testing was suggested, but the patient did not keep appointments for it. He maintained a most co-operative attitude, however, when seen on the ward and indicated that he would be down the next day or so.

After discharge from the hospital, the vocational counselor was notified that the patient had not co-operated in completing application blanks for state rehabilitation training. Follow-up with the patient indicated that this was true, and he then completed the necessary forms and made contact with the rehabilitation counselor.

The patient was rehospitalized, and when seen again, he indicated that he now felt that he would like to be a radio announcer. Although it was felt that he probably had enough general ability for this work, the choice was not considered to be a wise one because of his relative immobility, his physical appearance, his lack of training and general education, and his unreliability. After further counseling, he indicated interest again in the general office field.

After the veteran had again been discharged from the hospital, another letter was received from the state rehabilitation counselor. It was indicated that the patient again desired training in radio. He also now desired training in acting and felt that he could become somewhat of a star on the stage and in radio in a relatively short time. The counselor was attempting to discourage this.

Not very anxious to begin work to learn a new occupation.

Does what is expected when pushed.

Unrealistic plan.

Doesn't really want book-keeping but isn't willing to work out an acceptable plan.

Unrealistic and immature thinking. Hospital planning was not really accepted.

Good co-operation with state rehabilitation division.

Much counseling time spent without immediate results. A frustrating kind of patient to work with. The patient needed and wanted counseling, however.

Counseling Developments

Latest counseling and medical information was made available to the state counselor. The patient has not been heard from since. The hospital vocational counselor felt that little progress was actually made with this patient over a long series of interviews. It was felt that at best he would make a marginal work adjustment. Perhaps completing the GED tests helped him some in becoming more employable. It seems likely that he will spend most of his time home with relatives as long as they are willing to care for him.

Possible Implications

Veteran may plan more realistically at a later date. This is doubted, however, since he has spent many years, apparently happily, without needing to work regularly. Follow-up for about another year might be worthwhile to see if the patient has made any kind of a work adjustment or desires to re-establish a counseling relationship. This is also needed to get clues as to how the counseling might have progressed to a more effective end.

Patient B Test Results

<i>Test</i>	<i>Norm Group</i>	<i>Raw Score</i>	<i>T or S Score</i>	<i>%ile</i>
Bennett Mech. Comp. (AA)	Candidates for ap-			
	prentice tng.	51	67	95
Bennett Mech. Comp. (AA)	Engin. freshmen	51	55	69
High School GED's (B)	High school seniors			
Test 1	" " "		47	38
Test 2	" " "		55	69
Test 3	" " "		63	90
Test 4	" " "		68	96
Test 5	" " "		63	90

Name Patient B
PLEASE PRINT (LAST) (FIRST) (MIDDLE)

Date of Test _____

ADULT PROFILE SHEET

• FOR MEN •

For Form BB of the
KUDER PREFERENCE RECORD
Vocational
(Profile for Women on reverse side)

DIRECTIONS

Follow the directions below carefully:

1. Check to see whether all questions were answered. Then detach the answer pad from the test booklet by lifting the pad upward from the binding. ☐
2. Turn the answer pad over to the last page which is marked with the figure 1. Count the number of circles in which holes are punched, starting at the arrow. Do not count the cases in which there are three punches in a circle, since these punches represent errors. In the space for score 1 on the cover of the answer pad record the number of holes you have counted. ☐
3. Follow the same procedure for each of the other scores. Note that scores 2 and 3 are obtained from the same page, and that scores 6 and 7 also come from one page. ☐
4. Obtain the count again for each score, recording your answers in the spaces provided on each page, and compare these scores with those entered on the cover. In cases of differences, make the counts over again until you are sure the scores are right. ☐
5. Enter the nine scores in the space provided at the top of the chart on this page. Men should use the chart at the right; women should use the chart on the reverse side of this sheet. ☐
6. Find the number in column 1 which is the same as the score entered at the top of the column, and draw a line across the column at that point. Do this for each column. If a score is larger than any number in the column, draw the line across the top of the column; if it is smaller, draw the line across the bottom of the column. ☐
7. Fill in the entire space between the lines drawn across each column and the bottom of the chart. The result is the "profile" for this test. The examiner's manual contains suggestions for interpretation. ☐

JOB SUGGESTIONS for MAJOR INTEREST AREAS:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
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_____	_____
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Published by

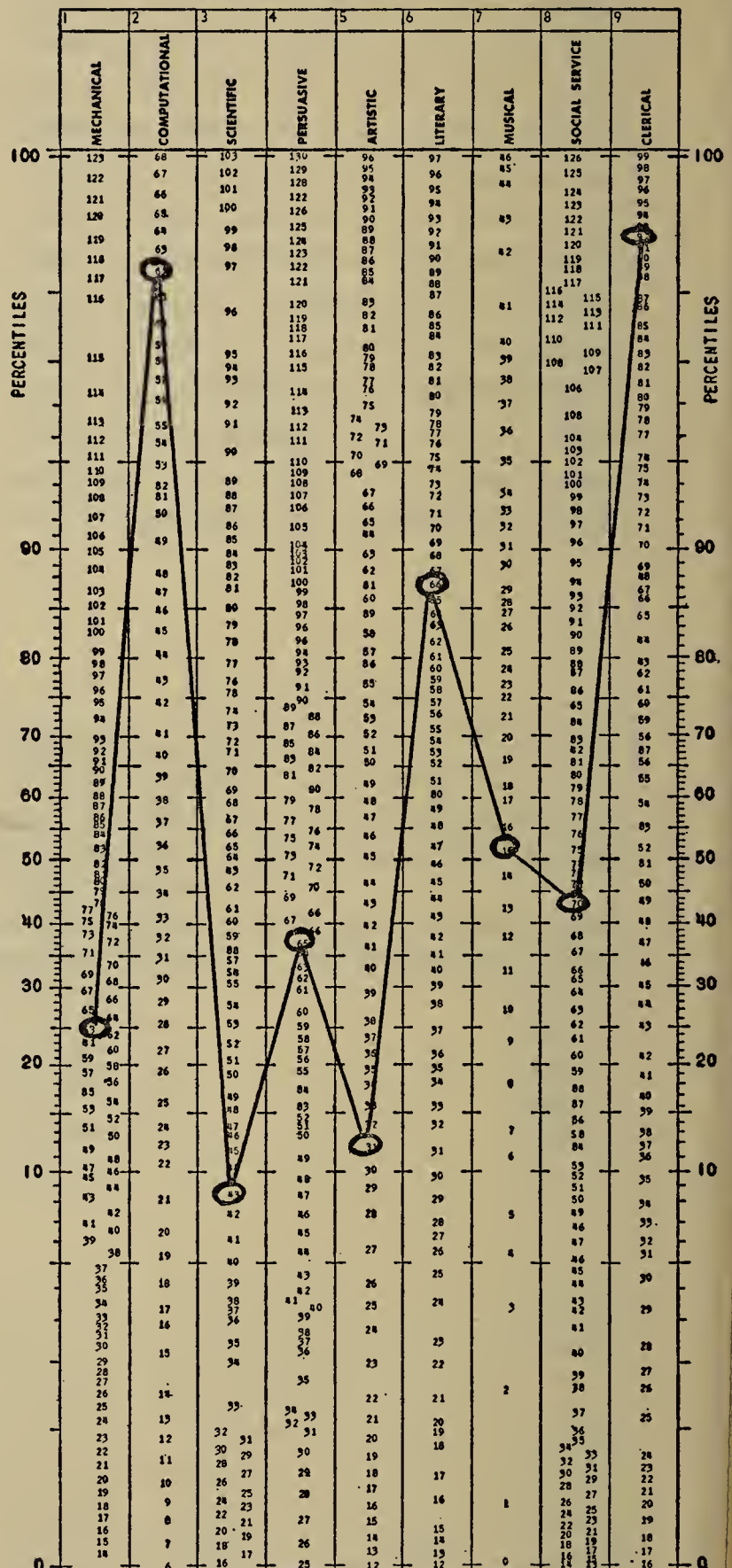
SCIENCE RESEARCH ASSOCIATES

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The Minnesota Multiphasic Personality Inventory
Starke R. Hathaway and J. Chamley McKinley

Patient B

Name

Address

Occupation

Date Tested

Education

Age

Marital Status

Referred by

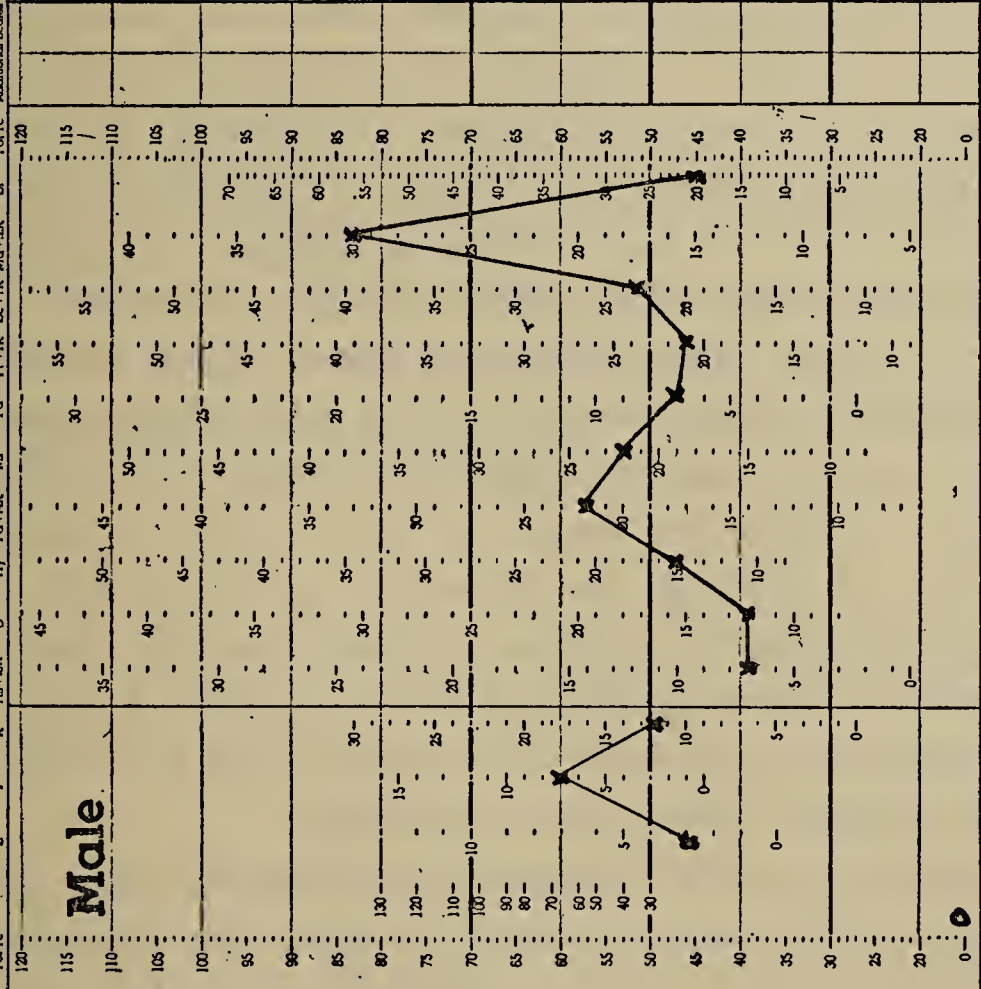
NOTES

M

Male

Scorer's Initials

For Recording
Additional Scales



Raw Score	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
9	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
10	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
11	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
12	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
13	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
14	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
15	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
16	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
17	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
18	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
19	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
20	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Raw Score

K to be added

Raw Score with K

SUMMARY

Orthopedics studies indicate that the number of amputations each year is high. They also emphasized the fact that full rehabilitation of the amputee patient requires the coordinated efforts of many workers, including the surgeon, the limb maker, the physical therapist, and all of the ancillary workers preparing the patient for gainful employment. The relatively new specialties in physical medicine have given more attention to total rehabilitation programs, particularly since World War II. There is good reason to believe that amputations represent a disability category in which counselors will be very active.

In providing some medical background for the vocational counselor, emphasis has been placed on the emotional shock that usually accompanies amputations, the desirability of preparing the patient for amputation, physical preparation of the stump for fitting a prosthesis, training in the use of a prosthesis, utilization of the lengthy convalescent period in the hospital, and the fact that in addition to substituting a prosthesis for a limb, the patient needs to overcome anxiety about his future. References are given which should help the counselor working in this area to learn more about such things as kinds of surgery, types of prostheses, and the problems of the double-leg amputee in learning to walk. The importance of patient participation in the total medical treatment program has also been noted. Sample questions to be resolved with the physician have considered such things as the limitations that may be superimposed by weight, skin grafting, diabetes, and poor circulation.

In connection with counseling the amputee, the patient's acceptance of his loss, the need to help the patient to become aware of the positive abilities he has left, the need to consider how the injury occurred, and the desirability of working with the patient's family have been discussed. It has been indicated that early contact with the patient by the

vocational counselor is desirable. Careful evaluation of physical capacities is necessary. It has been noted that placement of the amputee is easier than placement of many patients with internal medical conditions. The amputee's disability ordinarily is rather obvious, and placement usually is not difficult if the patient is given a chance to demonstrate how well he can use his prosthesis. The amputee can perform successfully in a wide range of jobs. A case study to illustrate vocational counseling problems with an amputee was given.

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12

The Heart Patient

PROBLEMS PRESENTED BY THE CONDITION

When a heart patient is referred for vocational counseling, the counselor will want to proceed cautiously. He will want to consult immediately with the ward physician on the patient's present physical status, his prognosis, and his psychological reaction to his condition and treatment. This consultation should take place before the patient is seen, even when written referral has been received from the physician.

If the vocational counselor has reviewed a number of articles or references on cardiac conditions, he will know that one of the more difficult aspects of treatment centers around the patient's own reactions to his condition. Patient fears, tensions, apprehensions often complicate diagnosis and treatment and may aggravate the patient's condition or lead to the development of cardiac crippling when little residual heart damage, after treatment, is discernible. Modell (97, p. 91) writes that "unnecessary restrictions have a deleterious psychological effect and do not protect the heart. For that reason neither the nurse nor the relatives should add to the restrictions imposed by the doctor." This would seem to apply as well to the vocational counselor who might unwittingly add to restrictions. Weiss (161, p. 271) states that anxiety with organic heart disease shortens the patient's years beyond necessity and will hasten cardiac breakdown "by all the extra effort he puts on the heart muscle because of the

emotional tug-of-war." Writing about cardiac neurosis, Weiss states further (161, p. 268) that for the doctor "to say to a patient like this after a casual examination, 'I don't think you have heart disease, but you had better rest,' and then to give digitalis is exactly the wrong thing to do." The vocational counselor should consider the implications for the patient, if the counselor, seeing him for the first time, blandly announces (or in some cases even suggests) that he is going to help the patient change to a job more in line with his disability. Certainly the counselor will have to know the facts of the patient's cardiac problems and the extent of his fears or acceptance before he can intelligently begin the counseling process.

Goldberger (69, p. 632) stresses that "the best treatment for cardiac neurosis is to prevent it." He also feels that "there has been a tendency on the part of the physician to underestimate the capacity of the heart for work and to protect the patient too much and for too long a period of time, especially in coronary artery disease." In addition, "if the cardiac patient is restrained and limited too much, a severe and incapacitating cardiac neurosis may develop and prove to be a much more serious liability than the actual organic heart disease." Counselors might profitably restudy cardiac cases that they have completed with an eye to determining how guilty they may have been in further limiting patients by arousing anxiety by too direct or even needless suggestion of change of occupation, particularly in the initial contacts. The playback and discussion of recordings should help a good deal in studying this in current counseling cases. A fair amount of space is being devoted to this matter of preinterview consultation with the physician in cardiac cases because it is felt that it has not been given enough attention and that the effectiveness of the whole counseling process may depend largely upon the care with which the first interview is approached. For many years the physician has been aware of iatrogenicity, or doctor-induced disease, and tries to avoid it. The coun-

selor should also realize that because he is regarded by patients as the person who helps seriously disabled men to find new occupations, he is actually in a position to easily induce additional or aggravated symptoms which harm the patient and interfere with the physician's plan. His interview methods and even the timing of his first approach to the patient should be carefully planned. Arenberg (7, p. 507), writing on chest injuries and iatrogenic heart disease, points out that inadvertent remarks, overtreatment, and too much emphasis on the cardiac area in the course of treatment may produce a real cardiophobia. He writes: "It seems that not even cancer arouses such fear as the suggestion that the patient might be suffering from a heart ailment."

The counselor, then, should consult as early as possible with the ward physician to learn about both physician and patient desires relative to counseling outcome in view of the restrictions or lack of restrictions in cardiac cases. To inquire intelligently into the patient's condition and treatment the vocational counselor should be familiar with at least some of the medical diagnostic terms.

MEDICAL INFORMATION FOR THE COUNSELOR

One reference (141, pp. 1, 2) lists the more common types of heart disease, classified according to cause, as follows:

Rheumatic heart disease, resulting from rheumatic fever, which tends to recur with possible additional damage to the heart each time.

Hypertensive heart disease, resulting when prolonged high blood pressure causes enlargement and eventual weakness or failure of the heart.

Coronary heart disease, developing when the coronary arteries which supply blood to the heart become hardened (sclerotic), and their channels become smaller, reducing the blood supply to the heart.

Syphilitic heart disease, resulting from the damage to one of the two large arteries leaving the heart (aorta) and its valve, caused by syphilis.

Congenital heart disease, resulting from structural defects present at or before birth.

Bridges (31, p. 155) states that the highest percentage of heart disease results from defective valves and that most valvular defects result from disease that causes the valves to become thickened and distorted so that they do not close properly (leakage) and allow some of the blood to flow back into the chamber from which it came. Stenosis of the valves is a narrowing of the size of the valve opening, because of scarring or fusion of the edges of the valve, which reduces blood flow. "Conditions that cause these valvular defects are inflammation of the heart (carditis), which may be inflammation of the lining membrane (endocarditis), inflammation of the muscle (myocarditis), or inflammation of the exterior membrane or sac containing the heart (pericarditis). These inflammatory conditions often result from rheumatic fever, sometimes from syphilis, scarlet fever, etc."¹ He says further (31, p. 156) that "the basic causes for the development of defective heart conditions are rheumatic fever, syphilis, high blood pressure, and arteriosclerosis of the coronary arteries. Obesity and overfatigue are contributing factors. Heart disease is sometimes a complication of other systemic diseases." He goes on to say that typical diagnoses are "angina pectoris, enlargement of the heart, heart murmurs, and leaky valves. Aortic insufficiency, mitral stenosis, endocarditis, and aneurism are illustrations of the more technically worded descriptive terms in use" (31, p. 156).

Angina pectoris describes "the intense, brief, suffocating pain in the chest which is brought on by exertion, excitement, or any temporary situation in which the flow of blood through the coronary arteries is insufficient." It "is often a symptom of coronary heart disease" (141, p. 2).

"Coronary thrombosis (a coronary occlusion) occurs when a blood clot forms in a narrowed coronary artery and cuts off the blood supply to a portion of the heart. This blockage results in damage to that area of the heart deprived of proper

¹ By permission from *Job placement of the physically handicapped*, by C. D. Bridges. Copyright, 1946, McGraw-Hill Book Co.

blood supply, a condition known as Myocardial Infarction" (141, p. 2).

An aneurysm is a bulge by pressure behind a thinner or weaker portion of an artery (aorta) (97, p. 18).

Subacute bacterial endocarditis is a complication of pre-existing heart disease, an infection of a damaged portion of the heart (97, p. 118).

Other terms it may be useful for the counselor to recognize are tachycardia (rapid heart beat), bradycardia (slow heart action), sinus arrhythmia (irregularity characterized by recurring periods of gradual slowing down and speeding up in the heart rate), systole (contraction), and diastole (relaxation) (31, p. 150).

Modell (97, p. 136) describes neurocirculatory asthenia as having a long list of synonyms: "cardiac neurosis, irritable heart, soldier's heart, disordered action of the heart, effort syndrome."

Since there are various kinds of heart conditions and the amount of apparent physical disability resulting will vary with the condition, the individual patient, the patient's reaction, age, weight, and other physical involvements, the counselor may find some knowledge of the functional and therapeutic classifications of the American Heart Association (141, p. 7) helpful in his discussion with the ward physician:

Functional Capacity	Therapeutic Classification
(Describes degree of limitation of physical activity caused by disease.)	(Describes the restriction upon physical activity necessary to prevent further damage to heart.)
I. No limitation of physical activity; ordinary physical activity causes no discomfort.	A. Physical activity need not be restricted.
II. Slight limitation of physical activity; ordinary physical activity causes discomfort.	B. Ordinary physical activity need not be restricted, but unusually severe or competitive efforts should be avoided.

Functional Capacity**Therapeutic Classification**

III. Marked limitation of physical activity; discomfort caused by less than ordinary physical activity.

C. Ordinary physical activity should be moderately restricted; strenuous habitual efforts should be avoided.

IV. Unable to carry on any physical activity without discomfort.

D. Ordinary physical activity should be markedly restricted.

E. Should be at complete rest, confined to bed or chair.

In speaking of functional capacity, the term *ordinary physical activity* describes the actual performance of which each person is capable prior to the onset of manifest cardiac disease. The functional capacity of the patient does not always determine the amount of physical activity that is permitted. The two classification schemes given above are usually used in some combined form, for example, II C.

Kessler (85, p. 367), in discussing this system of classification, feels that the best appraisal of functional capacity is work capacity based on appraisal while the patient is directly at work or in a rehabilitation center where the type of occupation can be simulated. In the hospital situation this might be suggested as an instance where occupational therapy or manual arts therapy simulating job-tryout situations might be extremely valuable. In addition, the counselor, with careful evaluation of previous work experience, may be able to contribute information that is useful to the physician in estimating present functional capacity level.

QUESTIONS TO BE RESOLVED
WITH THE PHYSICIAN

Armed with some understanding of the mechanics of heart disease (more complete accounts can be found in references 56, 69, 85, 97) and with some familiarity with the doctor's terminology, the counselor may wish to discuss questions like the following with the ward physician:

In patients with conditions such as rheumatic fever, hypertension, and arteriosclerosis, has actual heart damage been found?

Can the patient be tentatively classified according to the American Heart Association standards to aid in evaluating how much exertion on the job may be advisable?

Has the patient become a psychological cardiac worrier without or in addition to having actual heart damage? Does he seem likely to become overly concerned?

If he has had corrective heart surgery, has he much remaining physical limitation?

Should he avoid working in a contact capacity with many different people to avoid infections, or is it considered best psychologically that he feel normal about working with people, maintaining control of possible infections through the use of antibiotics?

Because of dyspnea or probable sudden coronary thrombosis, should he be kept away from work with machinery that might endanger him or others? Should heights be avoided?

Must his job be sedentary, or, if he works below capacity, is a standing job adequate? How much can he walk and stand? Are stairs too exerting for him?

Can he lift repeatedly? How much weight? Are there specific amounts to which he should be limited? Does the position from which he lifts matter?

What is felt about amount of exertion for this patient relative to the energy he expended in past jobs in his employment history?

Are sudden spurts of more strenuous activity to be avoided? Should daily activities require a fairly constant amount of energy output, or can he be required to work harder on some days of the week provided he always works below the limit of his capacity?

Is exposure to temperature changes or more than usual exposure to heat, cold, or wetness undesirable for this patient?

In this case how much should the counselor stress or avoid mentioning limitations? How well does the patient understand and accept his physical status?

From the standpoint of possible tension involved, should he be required in his job to drive a car, truck, or other machinery?

How necessary are regular hours, rest, daytime shifts, and so forth, for this patient?

Are dietary problems, such as maintaining a low salt diet, involved that may be difficult for the patient to solve in traveling jobs or in the industry cafeteria? Is the social worker planning this with the wife, relative, or company?

If there is a cardiac neurosis, will it be treated by psychiatric referral or through concerted team activity in a certain direction or both?

Again, it should be emphasized that in this and other sections only a few sample areas for counselor inquiry are given. Others will be suggested by individual patients and by the direction the counseling process is taking. The important point here is that the counselor become informed of the physician's knowledge of the patient and be able to get the medical information he needs to facilitate careful vocational planning with the patient.

COUNSELING CONSIDERATIONS

The cardiac is one of the more difficult disabled persons to sell to a prospective employer. Particularly if the person has been hospitalized for a cardiac condition, the employer often assumes poor prognosis and a short life span. Barker *et al.* (11, p. 365) state, for example, that the U. S. Civil Service Commission's manual (138) indicates that 53 per cent of 3000 jobs in a wide variety of industries (government employment and employment in industries holding government contracts) are inaccessible to persons with organic heart disease. Anderson (6, pp. 516-517), in 1941, speaking more generally about disabled persons, quotes the American Asso-

ciation of Industrial Physicians and Surgeons as having stated recently that

since the advent of the preemployment physical examination in industry . . . the physically handicapped person has frequently found his opportunities limited. While it is true that many industries do not discriminate against the physically handicapped when their proper placement is possible, it is also true that in others the nature of the work is considered to be unsuited for the employment of the handicapped; a supposition not infrequently based on an under valuation or lack of adequate interpretation of the handicapped person's functional capacity.

It is important in counseling to develop confidence in the patient that he can be productive and an understanding that when he meets a prospective employer he must emphasize his physical abilities rather than his limitations. The cardiac patient is often so impressed with his condition that he becomes a poor salesman of himself. Although the counselor does not usually wish to foster too much dependency, it may be necessary in this disability area to arrange, through placement officers, to have a third person present during the first interview with the prospective employer to help with the sales effort.

Cardiac patients can do a good job on their return to industry. Barker *et al.* (11, p. 351) report a study of 260 workers (including cardiacs in a group representing six disability areas) who would not have been hired under prewar standards, in which the conclusion was reached by the original investigators that "the disabled can perform the work assigned to them and have a favorable record of staying on the job." The Bureau of Labor Statistics (144, pp. 33-42) reported in 1948 that "the record of work performance of about 1800 workers with cardiac impairments was very similar to that of 3000 unimpaired workers matched with them on the same jobs." The study covered nineteen major industry groups and 104 plants. A broad range of skills was represented, with 5 per cent of the group in the unskilled category,

working as gatemen, porters, and similar help. They felt it reasonable to conclude "that the workers with cardiac impairments, properly placed, were not handicapped workers. As a group they displayed about the same work characteristics as the unimpaired workers subject to the same incentives and exposed to the same hazards, and were able to compete successfully with them." Information derived from studies such as this may be helpful in building the confidence of the counselor, the patient, and the prospective employer.

One of the most important parts of the counseling process with these patients will be a careful analysis of the physical requirements of the jobs under consideration. Following are some comments it might be wise to consider carefully. They should not, however, simply be accepted by the counselor. They are presented primarily to help him to think more carefully about his particular patient.

The patient with congestive heart failure "should be allowed to and encouraged to return to work as soon as the overt signs of failure regress and the feeling of weakness disappears. If possible he should be advised against heavy manual work, and excessive stair climbing, which is very strenuous. Many patients who are unable to do a full day's work, are quite comfortable working part-time" (69, p. 210).

"Travel by air may prove hazardous (except in pressurized planes) for patients with angina pectoris or coronary artery disease (or congestive heart failure)" (69, p. 254).

After acute myocardial infarctions, Goldberger (69, p. 505) cautions against lifting, hauling, or carrying heavy equipment or goods. He suggests that those who work in the city go to work a little late and leave a little early, if possible, to avoid the rush hour.

Kessler (85, p. 365), referring to hypertensive heart disease, says: "there is no convincing evidence that effort plays a role in its causation or activation, although it must be admitted that on rare occasion excessive exertion may cause failure."

He further states that "heart failure is rarely produced in the abnormal heart by exertion; infection is the most common cause."

In the rehabilitation of patients with rheumatic heart disease, improvement of diet and alleviation of overcrowded living quarters are stressed. The value of warmer climate is questioned, unless the patient is to remain there permanently (85, p. 374). Modell (97, pp. 211-213) feels that the effect of climatic change is small. In this same source psychotherapy is cited as playing "a great part in the rehabilitation of the patient with rheumatic heart disease. It is important for prevention or relief of a superimposed neurosis."

Patients with frequent attacks, such as those occurring in angina pectoris or heart block, should not be allowed to drive. Usual cases of rheumatic fever may be permitted to drive. Patients who do not drive well or are tense while driving should not be allowed to drive and certainly should avoid driving in heavy traffic for long stretches (97, p. 216). The Strouds (126, p. 118) feel it is safe to allow individuals who have had an acute myocardial infarction to drive three months or so after their acute episode.

Another reference (141, p. 5) states that "rheumatic cardiacs must avoid conditions that may lead to infection of the respiratory tract, such as dampness, humidity, and sudden temperature changes. Hypertensive cardiacs must avoid strenuous exertion and activities conducive to dizziness, such as stooping, jumping, climbing, etc. Emotional tension is harmful. In the most serious cases they should be restricted to sedentary work. Arteriosclerotic cardiacs must avoid strenuous activities, especially in the case of angina pectoris."

Another source (145, p. 65) states that since cardiacs should avoid worry and anxiety, "they should avoid occupations involving such factors as mechanical and electrical hazards, toxic fumes, explosives, and exposure to burns, etc."

Woodworth (171, pp. 164-166) describes increase in blood pressure and heart rate with sudden or startling stimuli and

cites evidence that excitement, pleasant and unpleasant, speeds up circulation. He also speaks of some increase in pulse rate in some kinds of mental work, especially if the conditions involve competition or working against time. Wolff (168, pp. 327–339) discusses the influence of life stress and states that “in emotional disturbances which may be severe and prolonged, the increased cardiac work and excessive tachycardia at rest and in response to exercise during anxiety, may be relevant to the increased susceptibility of patients with tachycardia to the development of structural heart disease.”

Strecker (124, p. 421) says that “the cardiovascular diseases are thought to have certain elements of psychogenicity in their etiology.”² In states such as anginal syndromes, coronary diseases, and hypertension, he holds that the “general pattern is one of frustration, failure of the environment to offer adequate outlet for tremendous amounts of aggression and hostility, and the damming up of this tension, etc.” Ruesch and Bowman (113, pp. 400–401) feel that “if the person happens to be neurotically inclined, physical treatment for psychogenic symptoms, inculcates in him the idea that there is nothing he can do to recover; he may then become an invalid.”

Modell (97, pp. 134–136) points out that patients with functional heart disease may suffer as much as those with organic heart disease and are a dissatisfied group. It is usually difficult to help them. They should not be neglected, and they do not get lasting results from a simple reassurance technique. Easby (56, p. 44) stresses giving these patients “a sense of security, an active outlook in a relationship with the doctor, and then with social contacts and in a vocation.” Attention to control of environmental difficulties also is emphasized. Davis (46, pp. 64, 65) further stresses that “functional

² By permission from *Practical clinical psychiatry*, by E. A. Strecker, F. G. Ebaugh, and J. R. Ewalt. Copyright, 1951, Blakiston Div., McGraw-Hill Book Co.

conditions may lead to organic changes if the condition becomes chronic.”³

For the counselor who reviews a fairly large number of references, it will become apparent that there is some disagreement on the amount of restriction to be imposed in various cardiac conditions. More recent references seem to tend toward allowing the cardiac more activity and allowing the appearance of symptoms to govern the amount of limitation. For example, Goldberger (69, p. 632) feels, especially in coronary artery disease, that “there has been a tendency on the part of the physician to underestimate the capacity of the heart for work and to protect the patient too much and for too long a period of time.” Kessler’s feelings on the role of exertion have already been cited. The Strouds (126, p. 118), discussing the treatment of myocardial infarctions, feel that “after an adequate collateral circulation has developed, it really does not seem to matter what these individuals do, within reason, from the standpoint of further coronary occlusions developing.” Ungerleider (137, p. 530), pointing up difficulties in diagnosis, feels that the best guide in the management of the patient with heart disease is the old dictum of Sir James McKenzie: “Allow the patient to do whatever he can do without developing symptoms.”

The counselor will also be struck by the fact that most references mention limitations or lack of them in a general way but qualify remarks for individual cases. It is obvious that the general limitations are useful for discussion and questioning but are applicable to individuals only after careful consideration with the physician.

Some specific suggestions the counselor might bear in mind in approaching the problems of counseling with cardiac patients are:

1. Consult with the doctor before the first interview.
2. Plan each interview carefully.

³ By permission from *Rehabilitation: its principles and practice*, by John Eisele Davis. Copyright, 1946, by A. S. Barnes & Company.

3. Avoid implying that job change is necessary, at least until you have decided with the physician that the patient has achieved a realistic acceptance of his limitations. Try to help correct unwarranted fears but don't expect to do so by a pat-on-the-back technique.

4. Know your limitations where treatment of a severe neurosis may be involved. At this point do not hesitate to suggest referral to the psychiatrist and the clinical psychologist.

5. Consider as little job change as possible if physical condition, job adjustment and satisfaction, and abilities are satisfactory.

6. Don't impose a general stereotype of heart disease on an individual patient with individual reactions to his condition.

7. Consider the progressive nature of the disease in your evaluation and planning. Lesions due to hardening of the arteries, for example, are likely to be progressive; but rheumatic fever lesions may be expected to be static (148, p. 40).

8. Recognize that the functional heart patient may be experiencing real pain and more frustration in securing results from treatment than the organic case. Don't dismiss him lightly. He may pose more of a challenge to counseling skill than the person with a relatively well-defined condition.

9. Realize that the cardiac has to recognize that the plan is within his physical capabilities. It is not enough for you and the physician to be satisfied that this is true.

10. Avoid repeating technical terms found in medical reports. This is not within the counselor's province, and, if done, is likely to produce either fear or confusion in the patient.

It is important to help the patient to develop positive reasons for his final job selections. His choices should not represent only those things that are left that he can perform safely (83, p. 206). Good interest and personality development in the counseling process would seem desirable, too, since happiness, lack of tension, a feeling of belonging, and physical normality are helpful and often necessary for these patients. Work with the social worker should help determine how the family reacts to the patient's condition, and whether the home aggravates his condition or really allows relaxation.

Since many of these patients have worked successfully at a job for several years, the counselor should try particularly

hard to find ways in which past experiences and training might be utilized in a similar, allied, or different occupation. Perhaps this can be achieved with an occupation that deals with the skills, knowledge, people, or products of the former occupation. Ordinarily, if this can be done successfully, there seems to be more patient enthusiasm and less feeling of having lost status and being physically different from others. In individual cases the counselor may wish to talk about such readjustment with past employers, union representatives, school officials, and placement workers.

In some cases, where it is obvious that the patient takes a need for change to less strenuous activity lightly and has no real intention to co-operate, the counselor may wish to suggest that the physician who has real prestige in this area work further with the patient on what he can or cannot do.

Since many of the heart patients will be older and further removed from the school situation, they may require more extensive orientation on the purposes of counseling, the usefulness of tests, and the kinds of occupational information that are available. They may also prove to be less flexible than some younger patients. Having spent many years at an occupation and having built up their own kind of economic motivation and philosophy of life, they cannot readily accept the sudden upset caused by an incapacitating illness.

ILLUSTRATIVE CASE STUDY

The case study presented in the following pages was selected to illustrate the importance of planning the vocational counselor's best point of entrance into the rehabilitation process. It should also illustrate that not all heart patients are left with disabling residual conditions; that anxiety can easily be aroused in patients; and that other problems, such as support of the family and desire for status, may seem as important to the patient as his immediate medical condition.

Patient C: cardiac-rheumatic fever; age, 25; modal prior occupation, factory machine operator.

Counseling Developments

This patient is a twenty-five-year-old, white, male veteran of World War II. He was admitted to the hospital with a diagnosis of acute rheumatic fever. He had no service-connected disability and no remaining eligibility for GI Bill training. The patient was referred for vocational planning during the early part of his hospital stay.

Consultation with the ward physician indicated that the extent of heart damage, if any, at the time of referral was unknown. It was felt prudent, however, for the patient to think in terms of lighter work on leaving the hospital. The physician indicated this to the patient, and the patient was seen on the ward. Intensive counseling did not begin until after a period of six weeks of strict bed rest. Since the patient was in a private room and had indicated a desire to participate in counseling, an interest test was given while he was still in bed.

When he was put on wheel-chair status, the patient traveled about the

Possible Implications

Early referral in this kind of a case calls for careful consultation with the doctor so that the patient is not unduly alarmed by the early appearance of the counselor, which might imply more severe handicap than may prove to be so.

Might have been better to have the counselor see the patient later when the extent of residual damage could have been easier to evaluate. The counselor could have suggested this.

Both the physician and the counselor gave the patient something to worry about during his period of strict bed rest. Actually little could be accomplished in this period—vocational planning might have started later.

Desire to participate in counseling at this stage was probably simply compliance with the physician's wishes. The possibility of generally depressed interest scores when tests are given during such a period, although not yet demonstrated, should be kept in mind.

Didn't tire easily. Friendly person. Basically active and

Counseling Developments

hospital extensively and was difficult to locate when wanted. Nurses felt that he was unco-operative, and the physician felt it necessary to talk with him about the seriousness of his physical condition. He was placed on an additional period of bed rest. At this point the vocational counselor also felt that the patient was immature and unable to settle down and face the possible seriousness of his disability. The patient maintained that he felt well, that he liked to talk to and help other patients, and that he was unhappy at being held any longer in the hospital. He also indicated that he might want to go into clerical or sales work of some kind when he left the hospital. Since the patient was to continue on strict bed rest for a while, the counselor closed the case for one month with the comment that "at the present time his main problem is to concentrate on being co-operative from a medical standpoint and getting sufficient rest so that he can begin to consider what his problems will be when he leaves the hospital." The counselor also felt that there might be some "basic emotional problems" back of the patient's inability to settle down.

The patient resumed counseling after about one month, coming to the service in a wheel chair. More complete interview and test data were obtained. He is married and has four children under five years of age. The wife cannot take employment because of the need to care for the children. The family has been living in a veter-

Possible Implications

outgoing. Had no activities of interest to occupy him. A good place for occupational or educational therapy on a diversional basis. Had expressed some clerical interests and could have been referred to educational therapy for exploratory work, possibly in bookkeeping. Counselor could have sold this as actually better than bed rest for the patient. Feeling the patient to be unco-operative, the counselor left the picture for a while—when he could have been most effective by arranging diversional activity rather than by starting counseling.

Counselor is too concerned with the patient seeing problems rather than possibilities.

Emotional problems were present but based on the immediate hardship being faced by his family while he was hospitalized.

Young children, no income, and housing-project life may be cause enough for worry and impatience with a rest routine.

Veteran's family not in a position to help much financially.

Counseling Developments

ans' municipal housing project. The patient's father is a disabled veteran of World War I who works at general labor jobs. The mother has completed two years of nursing training. The patient is the youngest of four children, having a brother who completed four years of professional training and two sisters who are housewives.

This patient left high school after ten-and-a-half years of schooling to enlist in the Navy. He says he liked high school. He had no Navy service-school training. After service he passed the High School General Educational Development tests and earned an equivalence certificate. After service he took six months of business school training in accounting. He then completed one year of VA-sponsored training in a state teachers college. He stated that he left college because he lived in a poor section of town and his family was discriminated against because of this. He says he did his best work in speech, American history, and science orientation. He had some difficulty with English. A check with the college revealed below-average grades. He says that he left college to return to the city to find work.

Employment history reveals rather low-level jobs. While still a student he did nursery work, was a handyman, a chauffeur, sold and delivered furniture, was a drugstore fountain man, and operated a sandpaper-cutting machine. He also had a paper route of his own. Prewar full-time work consisted

Possible Implications

Not able to achieve as much academically as his mother and older brother.

Probably about average general mental ability.

Expresses a desire for education but finds it very easy to leave school.

Feels a need to achieve academically.

Gives what he feels is a socially acceptable reason for leaving college. Actually was having difficulty at the college level.

Not able to achieve at a high level but was ambitious.

The bulk of his postwar work was probably below his level of ability and not at all challenging.

Sales interests begin to appear.

Counseling Developments

only of four weeks as a filing-machine operator. Postwar experience included a year and a half of sporadic taxicab driving and operation of a cardboard slotting machine in a paper box factory. This last job was the most recent and involved carrying bulky bales of cardboard. He describes it as heavy work. One summer he also did some heavy construction labor and sold for a short while in a retail sporting goods department. Of all his jobs he liked best those where he was able to meet and talk to other people.

The patient spent about forty months in service and had a good service record. He spent about thirty-eight months overseas at naval bases working as a machine gunner, ammunition passer, plane spotter, truck driver, bulldozer operator, and crane operator. He remained an ordinary seaman, achieving no specialty ratings.

He stated that he reads quite a bit, preferring magazines like *Newsweek*, *Time*, *U. S. News*, *Collier's*, and *Pathfinder*. He indicated that he does not like to build things and has as his hobby the collection of history and psychology books. He is not a hunter and not a fisherman; states that he doesn't like to drink but does enjoy dancing. He likes cards, bowling, swimming, and meeting new people. He used to be active in church, in the choir, as an altar boy, and teaching Sunday school. He met his wife at a church gathering. He mentioned also that he was active in debate during

Possible Implications

Was in service early enough and long enough to have done better with his ability.

Possibly an inflated version of his reading preferences. Was not observed by the nurses to read much at all, preferring to talk to the other patients.

Collecting books may be expression of a feeling that he should be competing more academically, possibly to equal brother's status.

More indications of sales interests.

Good personal qualities for sales or contact jobs.

Possibly overcompensating

Counseling Developments

his year of college. He has no automobile at this time.

The counselor's interview notes appraised the patient as presenting a good personal appearance, expressing himself very well, having a good sense of humor (almost too witty and happy), having more than average general mental ability, meeting people easily, and being a likable person. He was well liked by the other patients, but still felt to be quite unco-operative by the nurses.

Test results indicated average general mental ability with a score at the 64th percentile for army inductees on the Army General Classification Test (AH). Ability to understand mechanical principles on the Bennett Mechanical Comprehension Test (AA) was just average when compared to skilled-trades apprentice trainees. On the Minnesota Paper Form Board Test he scored at the 40th percentile for World War II males. Scores on the Minnesota Clerical Test were at the 62d and 42d percentiles for employed men on the numbers and names sections. On the Kuder Preference Record (BB) the patient scored at the 98th, 83d, and 79th percentiles on the social service, persuasive, and clerical scales in that order. All other scales were below the 55th percentile, with computational at 11, mechanical and scientific at 23, and artistic at 3. On the Strong Vocational Interest Test there were primary patterns in Groups IX and X, with low scores in Groups II, III, IV, and VIII. The MF score was rather low. On the

Possible Implications

for fears of physical condition.

"Lack of co-operation" is probably better described as not being understood on the ward.

Less measured general ability than he likes to think he has.

Ordinary potential for mechanical kinds of work.

Not much routine clerical ability, despite early expressed interests.

More evidence for a sales pattern.

Computational scale may help explain why he left accounting training.

Additional strength for consideration of sales jobs.

No evidence of feminine tendencies in interviews or history—probably not a problem.

No indications that he should attempt further college training.

Counseling Developments**Possible Implications**

Guilford-Zimmerman Temperament Survey scores were all rather high except for the MF score, which was in the direction of femininity.

When counseling was resumed after about six weeks of bed rest, he evaluated his own physical condition as precluding excessive physical activity, heavy labor, and standing for long periods. The patient was sent out on a one-month leave. He was given a checkup after this and advised to rest another two weeks to one month. It was felt that after this he might be able to begin half-time work activity. He called on leave to tell the counselor he wasn't ready for work yet since the hot weather was causing him to tire easily. The physician indicated there seemed to be very little residual heart damage.

During hospitalization and while on leaves he was very concerned about the stress on his wife and family. The social service worker arranged for rent and food allowances from the state department of veterans' affairs.

The wife suffered a nervous breakdown and was hospitalized for a short period during his hospitalization.

In evaluation interviews, the patient's original desires for clerical or sales work had now changed to a strong expressed interest in the social service area. He was interested in the plight of the poor, underprivileged children, and generally wanted to help people. He felt he should go back to college but guessed that now it was not economically feasible to do so. Saleswork, with some club work on the side, was

Marked change from his feelings when he was supposed to be on bed rest. He has come to consider his condition seriously—perhaps too much so.

Prescription of additional rest and suggestion of a half-time work tolerance would serve nicely to corroborate any fears that might be developing in regard to heart damage.

Felt physically worse on leave than his evaluated medical condition would warrant.

Social service referral helped to alleviate some of concern for family.

More reason to feel concerned and to find bed rest difficult to take.

Probably a reflection of his desire to be helped himself or his gratitude at being helped.

The Kuder score may also have had some influence.

Feels a need still for more education but also quickly rules it out.

Admits to himself that he does like sales situations.

Counseling Developments**Possible Implications**

felt to be the best alternative. He did not wish to go back to factory-type jobs. He felt that when he felt physically able he would like referrals for jobs such as retail clerk, appliance salesman, or insurance salesman.

In the next three months the veteran was in to see the physician several times about being overly tired, running a fever, and being short of breath. Each time he came to see the counselor, expressing the feeling that he was not yet ready for work but hoped to be soon. Consultation again with the ward physician revealed that although the patient should avoid heavy work and strenuous activity he was perhaps being overly concerned about the extent of his actual heart damage. The physician expressed concern that with a very small amount of actual damage, he was on his way to becoming a psychological cardiac cripple.

After this three-month period, the patient was rather desperate financially and asked for employment assistance. Arrangements were made for him to work with the state employment service veterans' employment representative. He indicated that he might try work now, since he was keeping in close touch with his family physician for checkups.

Follow-up indicated that the patient did not continue his employment service contacts but went out and secured sales employment on his own. He did rather well selling appliances and, later, used cars. About nine months

Overconcern about his physical condition. Excessive early cautioning and numerous checkups may have resulted in this poor adjustment after a good physical recovery.

Physician and counselor realize how much overconcern has been generated by overemphasis on physical limitations too early in the recovery period.

Family responsibilities force a trial at job adjustment.

Frequent checkups may serve to focus too much attention on physical state.

Able to sell himself easily when circumstances require it.

Original desire for more training at the college level is still active.

Counseling Developments

later the state division of vocational rehabilitation contacted the counselor for information on the patient. He had applied for training with them and was talking about the possibilities in the area of social service jobs. He did not, however, enter such a training program.

The patient was not heard from until about nine more months had passed. At this time he came in looking very prosperous and in good spirits. He indicated that he had just received a settlement on an old accident-injury claim. He had bought a good used car, new clothes for the family and himself, and some new furniture. He was out of work but felt confident that this time he would choose the right job and stay on it. He did not wish placement help from the counselor. He felt certain he would find a clerical or sales job. He also told the counselor that he felt fine and that recent physical examinations with his own doctor and an insurance doctor revealed no heart condition. He mentioned at least two more times that he was very happy and no longer had to be concerned about his heart condition. As he was ready to leave, the patient expressed a desire to file an application for a beginning clerical job at the hospital. He indicated that he thought a civil service job would give him security and a chance for advancement. He filed this application with the local chairman of the civil service board of examiners, and there was a possibility of his being hired in about two months.

He seemed quite enthusiastic about

Possible Implications

Main outside sources of anxiety are eliminated but he still feels a need to see the counselor—made a long trip to do so.

Doesn't admit he is probably still disturbed about adequate vocational adjustment.

Needed some sort of release but did not come to the point.

Protests so elaborately that he is now physically sound that the counselor felt he was still preoccupied with the possibility of a serious heart condition.

Since he has previously felt a need to achieve at higher levels and has experienced ability to make more money, and since he has more ability than would be utilized in this routine work, the counselor suspects he really wants to remain near his hospital and is actually greatly concerned over his physical condition.

Further indication of his ability to compete and sell himself when he wants to.

Patient will probably be seen over a long period. Realization that he is not a

Counseling Developments

this, even though he knew that the salary would be rather low and the advancement slow. He called the counselor two days later to indicate that he had obtained a temporary job as a punch-press operator turning out metal stampings in a machine shop. He said that he had claimed experience and, after watching a demonstration, had bluffed his way into the job. He mentioned again that he felt very good physically. Nothing further has been heard from this veteran.

Possible Implications

cardiac cripple may now have to be achieved by the slow process of having the patient discover from experience that his physical capacities are not impaired.
Had the patient been allowed more activity with less warning of severe consequences and had the counselor entered the case at a later date, both counselor and patient might have been saved considerable time and effort.

Patient C Test Results

Test	Norm Group	Raw Score	T or S Score	%ile
AGCT (AH)	WW II army inductees	86	109	64
Bennett Mech. Comp. (AA)	Candidates for apprenticeship	38	51	54
Minn. Paper Form Board (MB)	WW II males	38	47	40
Minn. Clerical Test—Nos.	Employed men	93	53	64
Minn. Clerical Test—Names	“ “	70	48	41

The following is a summary of agencies and specialists involved in vocational choice and planning with the patient:

In the Hospital

Agency or Service	Specialist
Medical service	Ward physician
Nursing service	Ward nurse
Vocational counseling service	Vocational counselor
Social service	Medical social worker
Personnel division	Chairman of board of civil service examiners

Outside the Hospital

State Department of Veterans' Affairs	Department representative
State teachers college	Registrar
State employment service	Veterans' employment representative
State Division of Vocational Rehabilitation	Rehabilitation counselor

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ADULT PROFILE SHEET

• FOR MEN •

For Form BB of the
KUDER PREFERENCE RECORD
Vocational
(Profile for Women on reverse side)

DIRECTIONS

Follow the directions below carefully:

1. Check to see whether all questions were answered. Then detach the answer pad from the test booklet by lifting the pad upward from the binding. ☐
2. Turn the answer pad over to the test page which is marked with the figure 1. Count the number of circles in which holes are punched, starting at the arrow. Do not count the cases in which there are three punches in a circle, since these punches represent errors. In the space for score 1 on the cover of the answer pad record the number of holes you have counted. ☐
3. Follow the same procedure for each of the other scores. Note that scores 2 and 3 are obtained from the same page, and that scores 6 and 7 also come from one page. ☐
4. Obtain the count again for each score, recording your answers in the spaces provided on each page, and compare these scores with those entered on the cover. In cases of differences, make the counts over again until you are sure the scores are right. ☐
5. Enter the nine scores in the space provided at the top of the chart on this page. Men should use the chart at the right; women should use the chart on the reverse side of this sheet. ☐
6. Find the number in column 1 which is the same as the score entered at the top of the column, and draw a line across the column at that point. Do this for each column. If a score is larger than any number in the column, draw the line across the top of the column; if it is smaller, draw the line across the bottom of the column. ☐
7. Fill in the entire space between the lines drawn across each column and the bottom of the chart. The result is the "profile" for this test. The examiner's manual contains suggestions for interpretation. ☐

JOB SUGGESTIONS for MAJOR INTEREST AREAS:

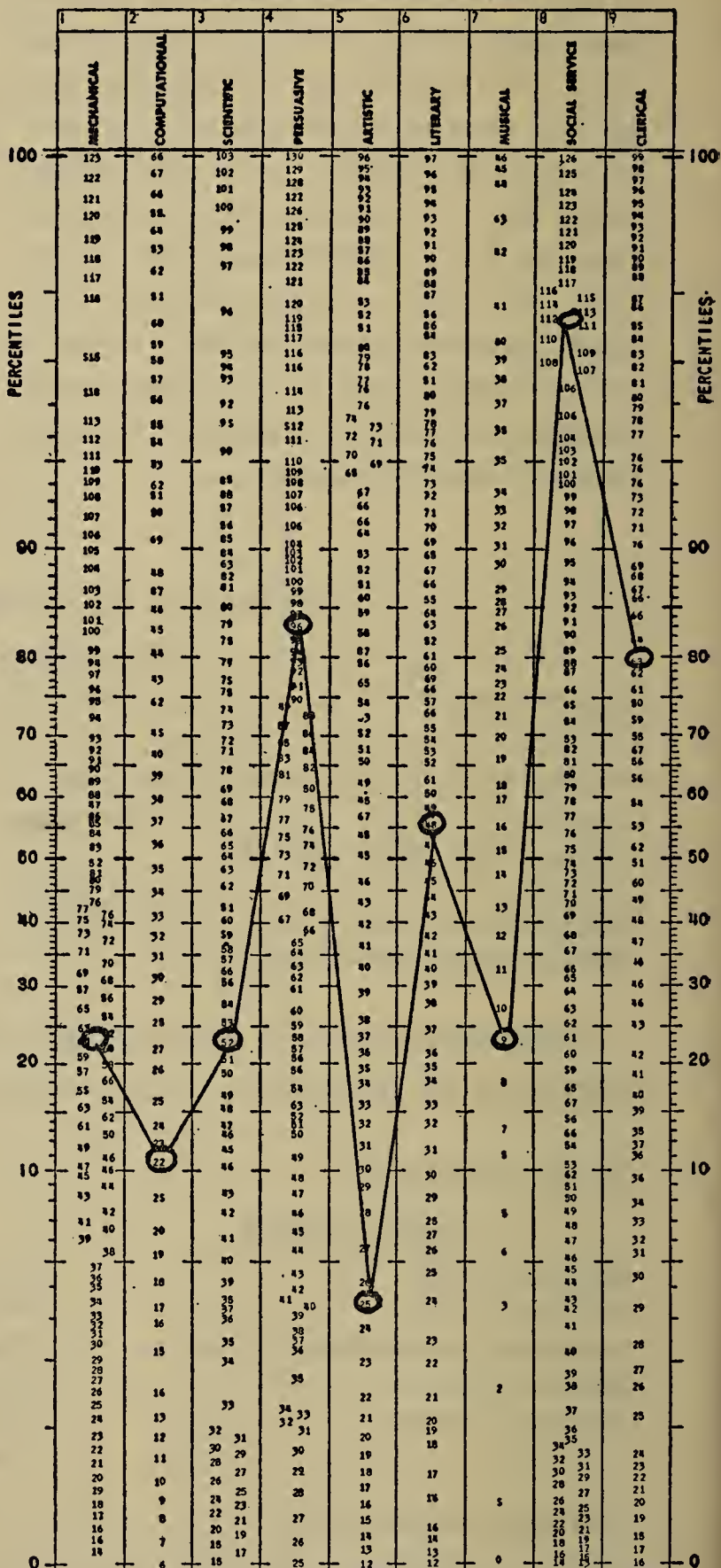
_____	_____
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Published by

SCIENCE RESEARCH ASSOCIATES

228 S. Wabash Avenue Chicago 4, Illinois

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STRONG VOCATIONAL INTEREST TEST—MEN

GROUP	OCCUPATION	0	10	20	30	40	50	60	70	
STANDARD SCALE										
I	ARTIST									
	PSYCHOLOGIST (REV.)									
	ARCHITECT									
	PHYSICIAN									
	OSTEOPATH									
	DENTIST									
	VETERINARIAN									
II	MATHEMATICIAN									
	PHYSICIST									
	ENGINEER									
	CHEMIST									
III	PRODUCTION MANAGER									
IV	FARMER									
	AVIATOR									
	CARPENTER									
	PRINTER									
	MATH. PHYS. SCI. TEACHER									
	IND. ARTS TEACHER									
	VOC. AGRICULT. TEACHER									
	POLICEMAN									
	FOREST SERVICE MAN									
V	Y.M.C.A. PHYS. DIRECTOR									
	PERSONNEL DIRECTOR									
	PUBLIC ADMINISTRATOR									
	Y.M.C.A. SECRETARY									
	SOC. SCI. HS. TEACHER									
	CITY SCHOOL SUPT.									
	MINISTER									
	VI	MUSICIAN								
VII	C.P.A.									
VIII	SENIOR C.P.A.									
	ACCOUNTANT									
	OFFICE MAN									
	PURCHASING AGENT									
	BANKER									
	MORTICIAN									
	PHARMACIST									
IX	SALES MANAGER									
	REAL ESTATE SALESMAN									
	LIFE INSURANCE SALESMAN									
X	ADVERTISING MAN									
	LAWYER									
	AUTHOR—JOURNALIST									
XI	PRESIDENT—MFG. CONCERN									
STANDARD SCALE		20	30	40	50	60	70			
INTEREST MATURITY										
OCCUPATIONAL LEVEL										
MASCULINITY—FEMININITY										

NAME

Patient 0

AGENCY OR SCHOOL

AGE

DATE

NUMBER

PROFILE CHART FOR THE GUILFORD-ZIMMERMAN TEMPERAMENT SURVEY
 SCALED SCORES FOR MEN

C SCORE	G General Activity Energy	R Restraint Seriousness	A Ascendence Social Boldness	S Social Interest Sociability	E Emotional Stability	O Objectivity	F Friendliness Agreeableness	T Thoughtfulness Reflectiveness	P Personal Relations Cooperativeness	M Masculinity (of emotions and interests)	CENTILE RANK	NEAREST T SCORE
10	30 29	30 29 28 27	30 29	30	30 29	30 29	29 28 27 26	30 29 28	30 29 28	30 29 28	99	75
9	28 27	26 25	28 27 26	29 28 27 26	28 27	28 27	25 24 23	27 26	27 26	27		70
8	26 25	24 23	25 24 23	27 26	26 25	26 25	22 21	25 24	25 24 23	26 25	95 90	65
7	24 23 22	22 21	22 21	25 24	24 23 22	24 23	20 19 18	23 22	22 21	24	80	60
6	21 20 19	20 19 18	20 19 18	23 22 21	21 20 19	22 21 20	17 16	21 20	20 19 18	23 22	70 60	55
5	18 17 16	17 16	17 16 15	20 19 18	18 17 16	19 18 17	15 14 13	19 18	17 16	21 20	50 40	50
4	15 14 13	15 14	14 13 12	17 16 15 14	15 14 13 12	16 15 14	12 11 10	17 16 15	15 14	19 18	30	45
3	12 11 10	13 12 11	11 10 9	13 12 11 10	11 10 9	13 12 11	9 8	14 13 12	13 12 11	17 16 15	20	40
2	9 8 7	10 9	8 7 6	9 8 7 6	8 7 6	10 9 8	7 6 5	11 10 9 8	10 9	14 13	10 5	35
1	6 5	8 7 6	5 4	5 4 3	5 4	7 6 5	4 3	7 6 5	8 7 6	12 11 10		30
0	4 3 2 1	5 4 3 2	3 2 1 0	2 1 0	3 2 1 0	4 3 2 1	2 1 0	4 3 2 1	5 4 3 2	9 7 5 3	1	25
	Inactivity Slowness	Impulsiveness Rhythymia	Submissiveness	Shyness Seclusiveness	Emotional Instability Depression	Subjectivity Hypersensitiveness	Hostility Belligerence	Thoughtlessness Extraversion	Criticalness Intolerance	Femininity (of emotions and interests)		

Active use should also have been made of the educational therapist, the occupational therapist, and perhaps the hospital rehabilitation board with this patient.

S U M M A R Y

Some medical background material has been discussed to give the vocational counselor familiarity with the more common kinds of heart disease. Such knowledge enables him to work intelligently with the physician in determining such things as amount of organic damage, extent of physical limitations, and desirable environmental conditions for the patient. Sample questions it may be desirable to consider in discussions with the physician have been given.

Recent references in the literature seem to favor more activity for cardiac patients. Most references stress the importance for the cardiac patient of avoiding anxiety over his condition. Iatrogenic heart disease has been discussed to point out how the vocational counselor may inadvertently increase a patient's anxiety about his cardiac condition.

Some of the more important points for the counselor to consider in working with heart patients include consulting with the physician before meeting with the patient; avoiding immediate and direct suggestion that a job change is necessary; avoiding a stereotype; considering individual limitations when working with cardiac patients; trying to capitalize on past experience in vocational planning; working with the social worker to achieve home conditions that allow relaxation but do not include overconcern about the patient; and realizing that the cardiac has to recognize that the vocational plan is within his physical capabilities.

In discussing job placement, it has been indicated that although cardiac patients have a good employment record as a group, employers often assume poor prognosis and short life expectancy and frequently are not willing to hire them. It is important to assist the cardiac in the first interview with an employer and to convince the patient of the need to em-

phasize his physical abilities, rather than his limitations, during an interview.

A case study illustrating vocational counseling with a cardiac patient was presented. Particular emphasis was placed on the period at which the counselor most effectively enters the rehabilitation process.

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13

The Hypertensive

PROBLEMS PRESENTED BY THE CONDITION

The hypertensive patient presents a rather unique challenge to the vocational counselor. His problems are different from those presented to the counselor by most other disabled persons. With the hypertensive the hospital counselor will probably find that he cannot proceed directly, with a fairly clear-cut assessment of abilities, disabilities, capacities, and interests, to help the patient arrive at a more suitable kind of occupation. He may find it neither desirable nor advisable even to discuss change of work with the patient.

A review of a limited number of references that apply to the rehabilitation counseling of hypertensives provides some basic information with which counselors should be familiar. One may generally define hypertension as higher-than-normal blood pressure, and it would be reasonable to state that a pressure reading above 140 indicates hypertension, though not necessarily hypertensive heart disease. The actual blood-pressure reading will vary some with age groups and with individual doctors making the diagnosis. One important point, in this connection is that rehabilitation workers should not draw conclusions from blood-pressure readings regarding the person's work capacity. This is properly the job of the physician, who is trained to take other factors into consideration when interpreting blood-pressure readings. Equally important is the fact that the hypertensive blood-

pressure reading is not necessarily indicative of hypertensive heart disease. Many persons seem to interpret high blood pressure as always including heart disease. As we shall see later, however, it is known that asymptomatic hypertension is not particularly limiting to the patient.

Another source (145, p. 66) defines essential hypertension as "a higher-than-normal blood pressure occurring without a demonstrable cause." It is also stated that it occurs with a high degree of frequency chiefly among people over forty years of age. Again, it is stated that arterial hypertension can exist with or without heart disease.

Becker (13, p. 378), discussing the incidence of the condition, states that "approximately 5 per cent of the adult population in the United States is afflicted with hypertension." One out of every four individuals in the United States past the age of fifty dies of hypertensive complications. "It has been estimated that approximately 55,000,000 days are lost yearly because of hypertension and arteriosclerosis." This same author appeals to hospital workers and physicians to avoid helping to make "blood-pressure invalids." Goldring (70, p. 167) tells us that elevated blood pressure should be regarded as a symptom and not a disease entity. Since in rehabilitation settings they are known to be working with the severely disabled, counselors should heed Becker's appeal.

It is the fear that hypertension may lead to such things as sudden death, uremia, heart failure, and "strokes," that serves to aggravate the existing hypertensive condition and impairs the patient's productive capacity (13, p. 379). The asymptomatic patient has a normal work capacity. The treatment of his condition includes prevention of a superimposed anxiety component (13, p. 383). The counselor will want, then, to be cautious about suggesting need for occupational change. In fact when he encounters this diagnostic category he probably will not wish to see the patient at all until he has had the opportunity to learn from the physician the extent, if any, of other physical involvements.

MEDICAL INFORMATION FOR THE COUNSELOR

It should be remembered that "hypertension *per se* in no way prevents a man from working" (13, p. 380). It is the more advanced symptomatology, resulting some time after the condition of hypertension is discovered, that will begin to limit him. Moreover, it should be noted that there is no clear-cut evidence that the associated effort of work in any way aggravates the hypertensive process or changes the natural course of the disease (13, p. 380). "Although effort affects the blood pressure, this is mainly confined to the systolic pressure and is of a transient nature." The same authority points out that disability results only when the patient develops "such symptoms as headache, hypertensive encephalopathy, and visual disturbances, or such complications as heart failure, cerebral hemorrhage, or renal insufficiency." Apparently, if a man likes his work and is not under constant tension, he should do as well as any other person. In conferring with the ward physician on symptoms and the amount of physical work advisable for the particular patient, the counselor probably will want to determine the amount of effort to which the patient has been accustomed and his present freedom from other disabling conditions.

Goldring (70, p. 169) feels that "patients with uncomplicated hypertension tolerate ordinary exercise well; however, they should not exceed their tolerance and should be advised to avoid vigorous and competitive sports. For those who lead a sedentary life, mild exercise compatible with the patient's tolerance should be encouraged. Occupations involving constant emotional tension are best modified by shortening the hours of work or by dispelling the urge to excel. In most instances it is unwise to suggest complete retirement when modification and partial curtailment are feasible." Becker (13, p. 384) states that "if a man works under intense emotional strain, however, it may be wise to restrict his activity only by encouraging shorter hours inter-

spersed with periods of rest and diversion. Changing the patient's livelihood is rarely of value."

In many cases the course of hypertension is fairly long, and the patient usually has a good period of productivity ahead of him. Becker (13, p. 383) states that "survival for more than twenty years, with comparative well-being, is not a rarity." There is little reason, then, for the counselor, unless so instructed by the physician, to look on these patients as disabled. His role will be to counsel as he would with a non-disabled person, to help prevent overlying anxiety, to develop hobbies and relaxing diversions, to help the patient to return to adequate employment, and perhaps to work out some readjustments on the job with the employer (possibly in terms of shorter hours or less responsibilities and tensions).

The counselor will want to avoid the implication that job change is advisable. It is easy to cause further tension by treating the patient like other disabled clients who need to consider job changes. It may be wise to discuss possible developments in his physical condition with the leg amputee; but such direct planning with the hypertensive is more likely to aggravate than to improve his present level of symptoms.

QUESTIONS TO BE RESOLVED WITH THE PHYSICIAN

It must be remembered here, too, of course, that no two patients will be alike physically or emotionally and that the counselor's first responsibility is to get a clear picture of the patient's status and the total treatment plan from his ward physician. No standard set of rules will apply. By no means should the vocational counselor adopt the view that he will be on the "safe side" if he considers and treats the counselee as a heart patient. This is a patient area in which it is particularly important to see the doctor before the first informal patient interview, if possible, even if a consultation sheet has been received from the ward. Following are some points the counselor may wish to discuss with the physician:

Does the patient have actual functional incapacity, resulting in symptoms, in addition to the diagnosed hypertensive condition?

If the patient is already employed and has only diagnosed hypertension, should the vocational counselor enter the picture at all? Will his presence suggest to the patient that there is reason to begin worrying about the physical effort involved in his job?

If the patient has developed severe symptoms, should the counselor assist mainly in the total treatment plan by limiting himself to superficial psychotherapy and the encouragement of relaxing hobbies and diversions?

If the patient has no functional incapacity but feels that he has, does he need encouragement to continue in his normal work? How completely has his condition been explained to him? Does he know, for example, that hypertension itself is compatible with longevity? What plan can be developed by all persons seeing him to help avoid unnecessary fears that may aggravate his condition and ultimately impair his productive capacity?

Since changing the patient's occupation has rarely been found to be of value, can the vocational counselor best be of service by trying to work out readjustments within the framework of the present job (perhaps in a way that seems to be rewarding or promotional) if this is possible?

If the patient is fairly upset emotionally, should referral to a psychiatrist be considered, or might this be too traumatic?

If the patient does seem to work under rather intense emotional strain or mental pressure, should shorter working hours, interspersed with diversional activity, be considered?

Since it appears that most emotional and mental strains play at least an accessory role in the genesis of essential hypertension, are there other available services, such as those of the social worker, occupational and educational therapists, contact officer, and mental hygiene worker, that should be brought into the total treatment plan?

Many other points may come up; these are but a few of the possibilities.

COUNSELING CONSIDERATIONS

The vocational counselor in VA hospitals may not yet have worked with a large number of hypertensives. Since the condition seems to occur chiefly in persons over forty years of age, however, increasing numbers of such patients can be expected from the potential World War II population within the next few years. It may be well to do some thinking now about the direction that the general counseling process might take with these patients.

Psychometric testing and evaluation should probably emphasize interest measurement, job satisfaction, job analysis data, and careful personality evaluation. Problem check lists may be useful. Good interest and job-satisfaction evaluation may indicate sources of undesirable tension or may substantiate the feeling that job change for the particular patient is not at all necessary. This kind of an approach may tend to put the counseling more on a personal-information basis and less on a physical-capacities level.

Personality evaluation should be done with great care. The development of a test with relatively neutral-sounding items might be considered. Interpretation of personality test results to the patient might be more damaging than the counselor may suspect, even with the intelligent patient who appears to be rather well adjusted. It may arouse further anxiety. Direct interpretation of a personality test to the patient, moreover, probably will do little more good than to give the counselor who feels insecure in his patient relationship a feeling of authority.

Wolf and Wolff (167, pp. 291, 322), in a study of 103 subjects with essential hypertension, found that their "hypertensive subjects, often gentle, poised, and apparently easy-going, were filled with aggressive drive, which was tightly restrained by a need to please. These findings are in general

agreement with those reported by earlier observers." In another study of ninety hospital patients with essential hypertension, these same authors found that an interest by the physician in the feelings, attitudes, and life situations of patients "reduced or eliminated symptoms in about two thirds. In a few, between one tenth and one fifth, the blood pressure was lowered to normotensive levels for significantly, if not indefinitely, long periods" (169, p. 489). Three aims in the management of the hypertensive patient, which may be worth consideration by the counselor as general guides for action, are set forth by Wolf and Wolff as follows:

1. To help him feel more secure.
2. To enable him to recognize that he felt threatened and hence angry and anxious.
3. To indicate how, when he did feel threatened, he might deal with the danger by more direct and appropriate action rather than by repression.

The foregoing points do not suggest that the vocational counselor at this point try to become a psychiatrist or clinical psychologist. Rather, they indicate that the counselor can do much, by effective job planning, to help the patient feel more secure and to take positive action if the security threat lies in his job or in family responsibilities tied to the job.

Complete interview information on hobbies, outside activities, school preferences, and so forth may become particularly useful in developing attractive diversional activities with this kind of patient. Becker (13, p. 384) feels that "hobbies and diversions have their definite place in the therapeutic regimen."

If the patient is intelligent but feels insecure because of his lack of formal education, use of tests to help him secure a high school equivalence certificate may be both therapeutic and useful in future job placement. Referral to educational therapy or manual arts therapy to learn additional knowledges and skills may also help to restore confidence and add to feelings of security. These activities may facilitate what-

ever adjustments to a present job may seem to be advisable.

Complete employment information will be necessary, since, if a job change is recommended, it will be best to recommend it to the patient in terms of capitalization on past experience, better utilization of aptitudes in connection with experience, economic gains, prestige, or some other such factor. Emphasis on job change in anticipation of advancement of the hypertensive condition should be avoided, not only because of the need to avoid anxiety but because the kind and extent of changes for the individual may be very difficult to predict accurately.

The social worker may help to avoid family and immediate financial stresses. The occupational therapist will aid concretely by developing hobby interests, contributing information useful in the counseling process, and providing relaxation and interesting activity to fill the patient's hospital day. He is in a good position to contribute data as to how the patient feels about his condition and the counseling process. The educational therapist can help build new skills or improve old ones. Often the contact officer can be called in to help settle administrative or disability claim problems with a minimum of discussion and worry for the patient. For example, if a pension or re-employment examination is scheduled for the near future, proper co-ordination may make it possible for hospital records to substitute for the examination. Repeated physical examinations probably should be avoided. Goldring (70, p. 168) feels that the patient's attention should be diverted from the level of his blood pressure.

The employer, family, and associates of the hypertensive can be most helpful if they avoid constantly protecting the patient and cautioning him against overwork. The counselor, on advice of the physician, or through the social worker, may be able to help in this direction. Patients who have really accepted counseling often will bring relatives and friends along when they visit the counselor.

ILLUSTRATIVE CASE STUDY

The following case study illustrates how the counseling process seemed to be effective in working out the problems of a rather typical hypertensive patient who was, at the same time, relatively without limitations from a physical capacities standpoint.

Patient D: possible bronchiectasis and essential hypertension; age, 37; modal prior occupation, driver and heavy equipment operator.

Counseling Developments

This thirty-seven-year-old, white, veteran of World War II was referred by his ward physician for vocational counseling because he was having difficulty in supporting his family while doing irregular and seasonal work. He was married and had five children ranging in age from eleven months to twelve years. The patient also felt that his recent jobs involved work that was too heavy for him.

The patient was admitted with diagnoses of both bronchiectasis and essential hypertension. The ward physician felt that he should be able to do moderately heavy work. His hypertensive condition was asymptomatic. The physician felt, however, that he may be bothered periodically by a chronic bronchitis condition. The patient had no service-connected disability and no remaining eligibilities for VA-administered training. He was interested primarily in job-placement assistance, feeling that he could not engage in a training program at this time and still support his large family. The patient also complains of backaches while driving a truck in his present work.

Possible Implications

Referral put on economic rather than physical basis by ward physician. This manner of referral attempts to avoid possible reinforcement of any anxiety about physical condition in a patient who need not be very limited.

Real financial need probably exists. Social service data are needed.

Work should not aggravate the asymptomatic hypertension.

Without emphasizing the fact to the patient, it is desired that he avoid heavy work.

Patient not as limited as admitting diagnoses might have seemed to indicate.

Patient concerned with family support; perhaps some unwarranted physical concern.

Counseling Developments

The patient came from a farm family of ten children. The father had eight years of education, the mother twelve. The patient completed nine grades in school. In addition he completed more than one hundred correspondence lessons in diesel engineering operation and maintenance. He started a correspondence course in air conditioning and refrigeration but did not complete the course. He stated that he left school after the ninth grade because he had to contribute to the support of a large family. The High School General Educational Development tests were mentioned, but the patient was not interested at the time.

In service the patient was a navy chief, supervising engine maintenance and operation and ordering fuel, water, parts, etc. He spent almost four years in service.

Prewar work experience included about two years as a rough carpenter, one year as an assistant manager for a lumber yard, and one year as a cat and carry-all operator. While still in school he worked as a farmhand on neighboring farms. After service the patient worked as a farmhand, heavy-equipment operator and installer, dairy-farm manager, and most recently (for about a year) in road construction as a heavy-truck driver and cat operator. He also had very brief periods of work as a coffee salesman and a house painter.

The patient's outside interests include reading (adventure stories), hunt-

Possible Implications

Probably little personal attention and guidance by parents.

Poor educational background.

Drive for more education or more skilled work. Ambition. Had to be self-supporting at an early age. Accustomed to responsibilities.

Preoccupied with financial problems.

Good service achievement. Must have demonstrated that he was responsible and capable.

Utilization now in mechanical or repair work is a possibility.

Largely unskilled, heavy work. On majority of jobs probably worked below his ability level.

Probably had to take any job available when unemployed in order to support large family. Not necessarily a true indication of interests.

Good range of outside interests when able to pursue them. Doesn't appear to have been favoring himself because he felt that he was physically limited.

Counseling Developments

ing, bowling, dancing, and playing cards. He has had little extra time recently to pursue these activities.

In the beginning interviews the counselor noted that the patient seemed self-assured and well adjusted. No emotional disturbances were evident. He expressed himself well and was judged to have above-average general mental ability. He presented a good physical appearance and had a pleasing manner in meeting others.

The counselee indicated that he liked heavy equipment work but felt that it was too heavy physically. He hoped to get work as a rural route carrier in his home community.

Test results indicated that the patient's general mental ability is well above average when compared to World War II inductees on the Army General Classification Test. Ability to understand mechanical principles was also indicated to be well above average when compared to beginning apprentices. Ability to work with spatial relationships was below average for World War II males.

Measured interests on the Kuder Preference Record were highest in the mechanical and social service occupational areas. Expressed interests were for mechanical kinds of jobs. The patient stated, however, that although he could secure such jobs in his small town area, he could not earn enough

Possible Implications

Makes a good impression.
Should help in placement.

Personality testing may not be desirable at this time. Need to find clues in the interview material. Mature individual.

May feel more physically limited than is necessary. May simply be reflection of need for steadier and better-paying work and, at the same time, assuring the counselor of willingness to work. Latter seems most likely with this man.

High-level general ability.

Apparently learned a good deal about mechanical principles in farm and heavy-equipment work.

Rather low aptitude indicated for work requiring spatial visualization.

Economic factors and job availability rather than abilities or disabilities would seem to be the factors requiring most attention. Care to avoid physical overconcern cannot be neglected, however.

Mechanical types of jobs again suggested.

Financial problem seems to be the most important one. Not a problem of being destitute but of needing higher salary. Did not wish social service assistance.

Counseling Developments

money in them to support his family. For this reason he had come to doubt his ability to provide adequately for his family. He felt that maybe he just did not have enough general ability. He also admitted some concern that additional physical limitations might make the task of supporting the family even more difficult.

After further evaluation interviews the patient was encouraged to check with local and civil service authorities on the possibilities for obtaining the rural postal route he has been dreaming of at some future date. He learned that he stood little chance of ever securing such a route, since other local applicants were likely to have first consideration. Although he did not wish to move his family he was urged to check job listings of the state employment service and the newspapers for both mechanical and route work in his local area and in the metropolitan area. He also followed the suggestion that he check on employment possibilities for route or route-management work for city newspapers in his home-town area. Applications for employment were filed by him with the newspapers.

The patient was discharged from the hospital with no physical limitations except for heavy labor. A letter requesting job-placement assistance in finding mechanical, assembly, or repair types of work was sent to the local veterans' employment representative of the state employment service. He felt it best to keep his large family in the small town and did not wish further

Possible Implications

Seems to be a fairly well-adjusted person faced with the reality of his local employment market. He needed assurance. Tests helped some in this regard. Most effective assurance can be given him by helping him find adequate job placement.

Vague hope for postal employment is tested and eliminated, making way for more realistic considerations. Counselor did not discourage patient. Patient took the initiative to check on this job.

Patient participation here is probably a good indication of real acceptance of the counseling procedure.

Explored possibilities with duties similar to those of the postal job he has wanted for a long time.

Good that physical limitations were not the initial basis for referral since he left the hospital with little limitation on activity.

Realistic—would perhaps find it even more difficult to support family in city.

Counseling Developments

placement efforts to be made in the larger cities.

After about one month, the counselee called to indicate that he was employed as a route supervisor, in his local area, for one of the city newspapers. He was quite happy with the arrangement, found the work light enough physically (the driving involved did not appear to bother him), and was earning a salary higher than that which he had received in driving road-construction equipment. He found it very easy to make route contacts, since his territory was centered in an area well known to him for many years. He was very grateful to the counselor for helping him to obtain this job.

The patient has not been rehospitalized at this hospital, and it is believed that he is making a satisfactory vocational and physical adjustment.

Possible Implications

Considering financial needs, patient's need to achieve in the community where he wanted to live, and ability to assume responsibility, it is probably just as well that mechanical knowledge and interests were compromised in terms of the realities of the local job market in his community.

Patient actually did the work.

Patient seemed most to need a chance to work steadily. Appears to have avoided overconcern about his hypertension and bronchitis.

If the counseling goal had been to limit the patient to sedentary mechanical bench work, as more than temporary employment, he might have found little opportunity for expression of his needs. It might well have aggravated both his family financial problems and his disability status.

Patient D Test Results

Test	Norm Group	Raw Score	T or S Score	%ile
AGCT (AH)	WW II army inductees	103	123	88
Bennett Mech. Comp. (AA)	Candidates for apprenticeship tng.	48	62	88
Minn. Paper Form Board (MA)	WW II males	36	46	34

Name Patient D
PLEASE PRINT (LAST) (FIRST) (MIDDLE)

Date of Test _____

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ADULT PROFILE SHEET

• FOR MEN •

For Form BB of the

KUDER PREFERENCE RECORD

Vocational

(Profile for Women on reverse side)

DIRECTIONS

Follow the directions below carefully:

1. Check to see whether all questions were answered. Then detach the answer pad from the test booklet by lifting the pad upward from the binding. ☐
2. Turn the answer pad over to the last page which is marked with the figure 1. Count the number of circles in which holes are punched, starting at the arrow. Do not count the cases in which there are three punches in a circle, since these punches represent errors. In the space for score 1 on the cover of the answer pad record the number of holes you have counted. ☐
3. Follow the same procedure for each of the other scores. Note that scores 2 and 3 are obtained from the same page, and that scores 6 and 7 also come from one page. ☐
4. Obtain the count again for each score, recording your answers in the spaces provided on each page, and compare these scores with those entered on the cover. In cases of differences, make the counts over again until you are sure the scores are right. ☐
5. Enter the nine scores in the space provided at the top of the chart on this page. Men should use the chart at the right; women should use the chart on the reverse side of this sheet. ☐
6. Find the number in column 1 which is the same as the score entered at the top of the column, and draw a line across the column at that point. Do this for each column. If a score is larger than any number in the column, draw the line across the top of the column; if it is smaller, draw the line across the bottom of the column. ☐
7. Fill in the entire space between the lines drawn across each column and the bottom of the chart. The result is the "profile" for this test. The examiner's manual contains suggestions for interpretation. ☐

JOB SUGGESTIONS for MAJOR INTEREST AREAS:

_____	_____
_____	_____
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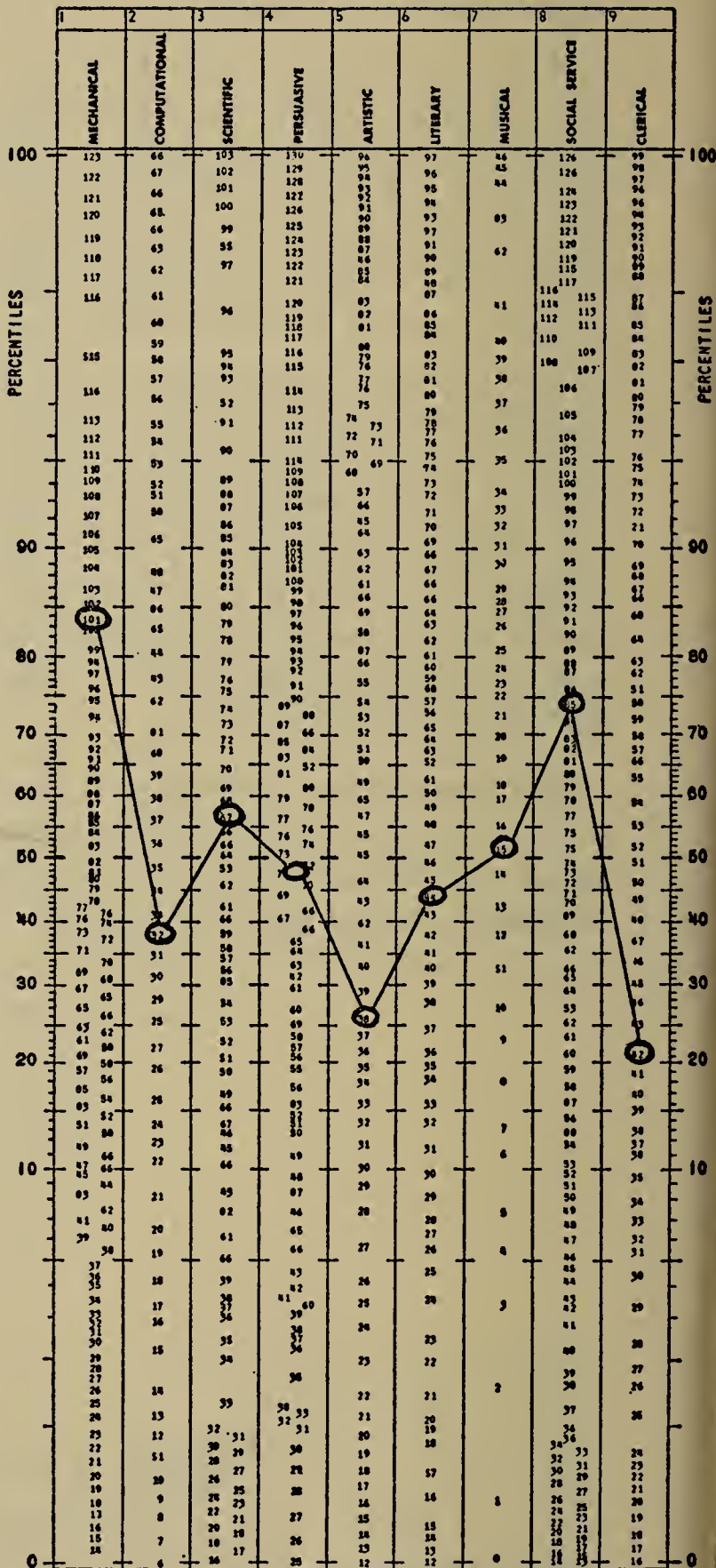
Published by

SCIENCE RESEARCH ASSOCIATES

228 S. Wabash Avenue

Chicago 4, Illinois

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SUMMARY

A review of the literature indicates that early discussion of the hypertensive patient with the physician to determine whether or not his condition is asymptomatic is important. Asymptomatic hypertension is not particularly limiting to the patient. Such patients apparently tolerate exercise well, and one writer tells us that there is no clear-cut evidence that the associated effort of work in any way aggravates the hypertensive process or changes the natural course of the disease.

It has been emphasized that the vocational counselor's approach when working with hypertensive patients may be quite different from his usual procedures. Job change may have little value and may not even be desirable. Attention should be given to relieving tensions and emotional problems and to working out readjustments within the existing employment framework wherever possible. Hypertensives should not be considered as heart patients unless it is known that they have developed cardiac symptoms as a result of prolonged hypertension. Complete development of information on work history, hobbies, and activities is useful in working out a plan of occupational readjustment with the hypertensive. With these patients the counselor should utilize the other paramedical services in working out hobby interests, diversional activities, increased competence on the job, emotional problems, and healthy family attitudes toward the patient.

A case study was given to illustrate what appeared to be effective counseling procedures with a hypertensive patient.¹

Selected References

BECKER, M. C., Rehabilitation of patients with heart disease, in H. H. Kessler, ed., *The principles and practices of rehabilitation* (Philadelphia, Lea and Febiger, 1950), pp. 361-388.

¹ It appears to be too early to discuss the general effects of drug therapy with these patients. The counselor will be interested, however, in its effect on his patient and on interview reactions and test performances.

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14

The Paraplegic

PROBLEMS PRESENTED BY THE CONDITION

Prior to World War II the paraplegic veteran was largely a problem for medical specialists and a person with poor prognosis in terms of both vocational adjustment and longevity. Kessler (85, p. 307) recalls that "veterans disabled by a spinal cord injury in World War I usually died very soon of spinal shock, or within a year from urinary, pulmonary, and other complications." During World War II, however, "with improved methods of controlling shock, modern surgical techniques, and successful handling of infection by streptomycin, penicillin, and sulfa drugs, paraplegic patients were saved. Now, with the application of intensive rehabilitation methods plus perseverance and courage on the part of the patients themselves, they can live useful and independent lives." Writing in 1950 (85, p. 307), this same author called attention also to the increase of paraplegics among the civilian population because of "greater mechanization and speed, and more frequent accidents of all types." It was estimated at the close of World War II that there were 2400 male paraplegic veterans and 15,000 male paraplegic civilians in this country (18, p. 49).

The paraplegics were probably the most dramatic group of patients for the neurologists, internists, urologists, and other specialists in World War II medical centers (85, p. 105). Certainly they have become a particular challenge and con-

cern to the vocational counselor, who now participates actively in the total treatment plan for the paraplegic, once the initial medical treatment is completed and rehabilitation, in and out of the hospital, begins. As more has been learned about medical treatment and control of the condition, longevity has increased, and some patients have demonstrated a marked capacity for good personal and vocational adjustment. As a consequence, more attention has been directed toward utilization of the hospital stay for the careful planning of a productive posthospital future. Bloom (23, pp. 46, 47) illustrates this change in approach from the largely medical treatment to the team method and gives us some idea of the many professional people now active in paraplegic rehabilitation when she writes:

Since by definition, "rehabilitation is the restoration of the handicapped to the fullest physical, mental, social, and economic usefulness of which they are capable," each member of the team (physician, psychiatrist, physical therapist, occupational therapist, nurse, social worker, recreational worker, teacher, clinical and vocational psychologist) works with the paraplegic, in his special capacity, to achieve a common goal.

There will be few patients for which the vocational counselor will find himself participating in as many interprofessional relationships as the paraplegic. The team will lean heavily on him, even though he is faced with placement of an extremely disabled person. Since the patient will be hospitalized for a long period and probably be a rather dramatic case, many professional persons are likely to become ego-involved with the patient's progress and to have opinions. Many of these will be helpful; some may complicate patient and counselor decisions. In any event, the counselor is likely to be pushed rather quickly for a vocational plan. Furthermore, the long hospital stay and the extent of disability are apt to produce certain adjustment problems in the hospital which will involve the counselor in additional planning, not only to resolve them but to provide the patient with activity that may have value after hospital discharge. Often this

planning must be done with incomplete counseling data, since the patient may not have adjusted well enough to his condition to wish to participate actively. It would seem, then, that the vocational counselor should have some background for working with paraplegic patients.

MEDICAL INFORMATION FOR THE COUNSELOR

Some medical orientation is desirable. Baker and Brown (9, p. 39) describe paraplegia as customarily referring to "a paralysis of the lower limbs associated with impaired control of the bladder and bowel." In more detail, Berger (18, p. 46) states:

Paralysis of both lower limbs is spoken of as paraplegia. More or less of the trunk may also be involved in the paralysis, and in some cases sensation of these parts is affected. This paralysis is caused by damage to the spinal cord, and this damage may be the result of a gunshot wound, a fracture-dislocation of the spine, acute inflammation such as transverse myelitis, or a disease of the nervous system such as anterior poliomyelitis, to mention a few of the many conditions which may produce the nervous lesion. The type of paralysis may vary in nature, and in degree, the specific disability depending upon the site and extent of the pathology in the nervous system.

Other medical complications, according to Berger (18, p. 48), may be pain requiring chemical or surgical procedures, bladder infection, kidney infection, or bed sores (decubitus ulcers). Baker and Brown (9, p. 39) state that immediate care of the patient "consists of the carrying out of indicated surgery, the care of the skin, bladder, and bowels, prevention of contractures, and the preliminary strengthening of the upper extremities as a prerequisite to ambulation." Kessler (83, p. 175) indicates that constant training and practice can change the whole picture for the paraplegic: "even in the presence of loss of control of bowel and bladder, he develops, through habit training, regulation of these functions which permits him to get about without difficulty or embarrassment." Delay in treatment or progress on the rehabilitation

plan may be caused by serious infections (kidney or bladder) or procedures required to treat and close bed sores. Decubitus ulcers are a very serious problem in paraplegic rehabilitation (85, p. 310).

QUESTIONS TO BE RESOLVED WITH THE PHYSICIAN

The vocational counselor must remind himself that paraplegics exhibit individual differences just as is true of patients in any other group. No one pattern of reaction fits all of them physically or psychologically. Physically, "the resulting destructive changes depend upon the level of the lesion" (85, p. 308) and the additional medical complications. Psychologically, it would appear that "there is essentially no one type of personality structure which accompanies a paraplegic disability. We find that the personality of the paraplegic patient is as varied as are personality structures in any normal population. There are as many severely disturbed, as many well adjusted in both groups" (18, p. 50). With these factors in mind, the counselor will want to consult the physician along the lines of some of the following sample questions before starting a long series of interviews to formulate pre-vocational and vocational plans:

What is the kind and level of the lesion, and what destructive changes have resulted? Are there some losses of function that appear to be temporary and may improve?

What is the patient's status as far as bladder and bowel control are concerned? Will habit training be likely to help?

Are there complications, such as renal conditions, which will greatly limit the activity and life span of the patient?

Are there any things that should be avoided because of loss of sensitivity in the lower extremities?

Are decubitus ulcers an important problem with this patient? Will he have to avoid certain sitting positions for long periods of time on a job? How long a period can he sit?

Is this patient likely to have frequent future periods of hospitalization?

Should he be urged to be rather active to avoid additional medical complications, such as pulmonary embolism?

Is crutch walking a possibility for this patient? Will it be effective after discharge from the hospital or is it likely that he will resume wheel-chair life?

Does he have good strength in his upper extremities for such activities as lifting, bench work, crutch walking, propelling a wheel chair up a ramp, and pulling himself in and out of a car?

What is the present level of self-care activity, and to what extent is it likely to improve?

How was the patient injured, and how does he react to the cause of his condition? Is he behaving well on the ward?

Does the patient seem to be adjusting well to his disablement, or does he hold false hopes for return of some irreparably lost functions? How do his visitors (relatives) adjust to the idea of his being permanently disabled?

How thoroughly has the physician explained his condition to him? Does he seem to understand and follow medical directions?

Is he well motivated to achieve a better level of functioning, or does he seem depressed and overly dependent on ward personnel?

COUNSELING CONSIDERATIONS

Having obtained answers to questions of the kind considered in the preceding section, the vocational counselor will want to consult carefully with physical medicine personnel, particularly with the physical therapists and the corrective therapists. They will have noted carefully the patient's present activity level, so that progress can be evaluated. They will also be able to tell the counselor what activities are planned and to give evaluations of progress. Physical medi-

cine for these patients begins as soon as possible after the injury (85, p. 308). In hospitals and centers where such devices as having the patient record his progress in functional activities on individual charts are in use, the counselor can both learn of physical progress and motivation and help the total treatment plan by showing interest in the patient's score card. Other physical medicine activities, like manual arts, occupational, and educational therapy, will enter into the rehabilitation plan somewhat later. Here, however, it is hoped the counselor will be most active in actually helping to shape the work as prevocational activity, being interested, of course, in physical progress but not limited mainly to that as in the physical therapy stage.

Just as the physical therapist carefully notes the patient's present activity level, the vocational counseling psychologist should find it useful to make case notes of initial appraisal of interests, motivation, and acceptance of the counseling idea for use in evaluating future progress with his patient. As the counseling progresses to the development of tentative interests and the selection of general fields of vocational activity to be followed by prevocational tryout, the counselor may find it useful with some patients to have them diary their tentative choices for comparison with similar points of choice at a later date. The notion of the patient keeping a counseling "score," as he does with functional activities, may help him to see that he is making progress in accepting his physical condition and toward productive posthospital employment.

The psychiatrist, social worker, and clinical psychologist may be able to give the vocational counselor information on present adjustment to disablement, adjustment pattern prior to the injury, and the kind of home attitude the patient is likely to return to on leaving the hospital. Berger (18, p. 51) states that "some paraplegics may consider their disability on a very objective level—others may consider the paraplegia as a complete destruction of their entire body, while still

others may respond to a paraplegia with almost a complete denial of any bodily disturbance." Bloom (23, p. 47) feels that "depression is the general reaction of most individuals when they begin to realize the severity of their injury." Further, "as they begin to accept disability, they may either mobilize those defenses which will assist them in their rehabilitation or they may reject treatment and believe it is only a matter of time until they are cured."

In evaluating reaction to disablement, the counselor should not make snap judgments. The patient has become severely disabled. He is likely to have many anxieties. Suddenly he is dependent, may feel unattractive, his mobility is restricted, he cannot control soiling, he may fear falling, he may have developed bed ulcers. He suddenly has a good deal to accept and integrate into his own concept of himself. He has become a profound physical and psychological problem, not only for the medical team but for himself. Kessler (85, p. 321) feels that "common sense, patience, ingenuity, and the ability of the physician to put himself in the position of the patient will have much to do with whether or not he continues to have a defeatist attitude with regard to rehabilitation or whether he attempts to help the patient to gain even a small degree of independence." The same kind of thinking might apply to the vocational counselor whenever he feels frustrated at his seeming lack of progress with a particular paraplegic patient. Progress may appear to be very slow. One writer (18, p. 51) feels that "the integration of a physical disability into the patient's body image takes considerable time—usually during the first year with the paraplegic." During this period, the patient may appear depressed, withdrawn, or little interested in vocational planning for return to employment and his community. Counseling work in this disability area would seem to require continuing visits, even when the patient's acceptance of counseling is not at all clear for relatively long periods of time—even at the possible expense of having imposed counseling upon the patient.

As an aid in determining patient reaction and real desire to plan, the counselor might consider Bloom's description (23, pp. 47, 48) of three kinds of reaction to paraplegia. She describes an "adequate reaction," where there is good insight and "counseling can start together with the physical program"; a "dependency reaction," where "simultaneous work by psychologist, social worker, and psychiatrist may be necessary"; and a "psychopathic reaction," where the individuals are pleasant and co-operative, but "lack of motivation reveals itself as they near their vocational goal." The last kind of patient may be the one who breaks many appointments, over-concentrates on the physical program to the neglect of other activity, slows down as he becomes ready for discharge, puts off final vocational planning, and generally refuses to face up to going home again.

It should be remembered also that paraplegic patients who are veterans with service connection, drawing compensation for their condition, ordinarily do not have economic problems, and because of this, may well lose motivation to become vocationally productive and to feel the satisfaction of contributing to their own support. Ordinarily, the physician will encourage the counselor to motivate the patient to leave his home and to work regularly. The time when life expectancy for the paraplegic was very short and the vocational counselor helped plan only for limited homebound hobby activity has passed. Although a disability allowance helps greatly in the initial adjustment on returning to community life, in some cases it seriously hampers the process of making realistic job choices and makes homebound activity attractive to the patient, even though this might be medically or economically unsound. There are some few patients, however, where homebound activity is the best that can be hoped for.

Deaver (47, p. 62) feels that in the treatment of patients with spinal cord lesion, "the psychological factors necessary

for consideration are those that relate to personality changes resulting from the loss of motion, sensation, bladder, bowel, and sexual functioning." Barker *et al.* (11, pp. 131, 132) cite a study by MacLaughlin, based on Thematic Apperception Test stories of twenty-five male veteran paraplegics, which shows these men had "high valuation of health and strength, lack of emotional control, psychosexual maladjustment, although not on a conscious level, depression." Berger (18, pp. 52, 53) emphasizes the psychological importance of excretory processes as related to ideas that parents have built up; sexual problems as related to social concepts about impotent males; and feelings of uselessness and loss in physical appearance in terms of cosmetic values. The counselor would seem to be on most solid ground if he remembers that the patient has real and difficult immediate adjustments to make for everyday living. These may be complicated by preinjury personality patterns; but without evidence of such complication, it seems unwarranted at this time to draw conclusions about depression over impotency or childhood fears of soiling the bed. Rather, it seems best to assess present problems and think as Berger does when he states later (18, p. 57):

In a sense what we psychologically observe in the paraplegic is an exaggeration of problems which are common to many nondisabled persons. Where the person has always been mature and well adjusted he will react to the paraplegia in just that manner. Where the person has always been infantile and poorly adjusted there will be just that type of reaction to the disability.

The influence of the family can be important to the attitudes and motivation of the paraplegic. The social worker can help the counselor to learn whether or not the wife is realistic, likes to be maternal, feels herself a martyr, fosters dependency, expects too much of the patient, and so forth. The counselor will probably want a chance to talk with the wife when she visits the ward or sees the social worker. Since the wife will probably make many visits to the hospital, a

planned educational program with her can be worked out by the physician, social worker, and counselor, if this is necessary to the patient's adjustment.

Following are some specific things the counselor should keep in mind in working with the paraplegic:

Help the patient to know that paraplegics generally can work a full day, drive a car, and lead a fairly normal life. Pointing out the success of some previous patients may help if done at the right time.

Realize that although the patient may do crutch walking, such patients ordinarily need sedentary work and will be working from a wheel chair or bench.

Do not be concerned with life expectancy, since, for most patients, it is not now extremely short and usually is not predictable.

Realize that the patient is likely to be quite aware of his limitations and that enough attention has already been given to affected areas; he may be poorly informed about his remaining capabilities.

Realize that true motivation to be productive may be one of the most important areas for work, particularly with patients drawing disability compensation.

Be patient, thinking in terms of long-time counseling, since adjustment to the disability may be slow. The patient will be there for a relatively long period. Several short interviews, starting early in the hospitalization, may be the better approach. With these patients there is every opportunity to get to know the family and the community situation to which the patient will return.

Realize that home businesses are not too profitable unless careful plans for demand, outlet, and delivery have been made.

Bear in mind such very practical considerations for job placement or training as ramps, elevator service, special parking permits, aisles and doors wide enough for wheel-chair travel, accessible rest rooms, personal hygiene, and impaired

mobility in a dangerous environment. Work in this disability area points up the necessity for counselors to be familiar, from firsthand visits, with the business, school, and trades facilities in the immediate area.

Make the most of a long hospital stay by prevocational trial and training in the job areas available in such services as educational therapy, occupational therapy, and manual arts therapy.

Consider that since the paraplegic is so obviously disabled, he needs special skills that are saleable to the employer. The more of these skills he can acquire the better. Placement on a sympathy basis may not last long and will not give the paraplegic much of a sense of real achievement.

Explore vocational and hobby background thoroughly. It would seem desirable to capitalize on all that is left, making as few additional adjustments necessary as possible.

Consider the demands of planned occupations in terms of both abilities and physical assets. If the occupation is too demanding and the patient fails, he may feel that further effort is useless because of his general physical inadequacy. On the other hand, if the job is too easy, it may not seem worthwhile and challenging, and he may feel a simple job has been created to delude him into feeling that he can be productive.

Consider counseling a part of a larger continuous team effort. With these patients the counselor will need to make frequent use of other professional persons.

For patients with a history of unskilled job experience who have no VA training eligibilities, the facilities of the local state rehabilitation division for training in a skill should be utilized in almost every case.

Since paraplegics in a community seem to be a rather closely knit group, good counseling and placement of one or two patients will help greatly in motivating others and should help also to create additional placement opportunities.

ILLUSTRATIVE CASE STUDY

It is hoped that the case study presented below will illustrate some of the problems that the vocational counselor may meet in his work with young paraplegic patients. Some examples are the periodic interruptions of training for medical treatment; the patient's problems in adjusting to a new physical status; and the need to arrange for counseling follow-up and assistance when the patient leaves the hospital. Although these problems are typical for paraplegics, this case study is not representative of all paraplegics, since it also presents other medical complications and the question of race.

Patient E: paraplegia; age, 23; modal prior occupation, high school student.

Counseling Developments

This patient is a twenty-three-year-old, single, Negro veteran of the Korean period who lives with his parents. He has no service-connected disability and no eligibility for rehabilitation training under VA sponsorship. He does have eligibility for thirty-six months of GI Bill training. While still in service he was hospitalized with a diagnosis of anemia. He first entered the VA hospital for treatment of this condition. He was not referred to the vocational counseling service at this time.

About one year after discharge from the hospital the patient fractured his spine in an automobile accident. The injury caused complete lower extremity paraplegia. He was admitted to the hospital for treatment of the paraplegia, with the inherited anemia condition. Shortly before discharge from

Possible Implications

No family responsibilities. Eligible for training but will be dependent on family for support. No service-connected disability. Future employment will probably be interrupted by periods of treatment.

Unfortunate that he was not referred; it would have been interesting and helpful to have known him before his paraplegia.

Sudden change from active life to complete paraplegia.

Possibly a difficult combination of disabilities.

Decubitus ulcers probably will appear and require periods of treatment in a hospital.

Counseling Developments

this period of hospitalization, the patient expressed a desire for vocational training and was referred to the vocational counseling service.

At this time the patient indicated that he was interested in further training at the college or business-college level and hoped to earn a diploma or degree in the field of business administration.

Counseling interviews revealed that the patient left school while in the eleventh grade to join the Army. In high school he liked arithmetic, mathematics, and history and did average work in these subjects. He had difficulty with English.

His only other formal school training consisted of a course as a radio operator while in service. He served about three years as a ground radio operator.

Work experience prior to service was limited to part-time and summer jobs as a shipping clerk, bus boy, maintenance worker for a railroad, and railroad car inspector. After service he worked for a short period as a parts clerk and helped on his father's summer resort.

Prior to his injury he had been an active young man, participating in such activities as tennis, bowling, and dancing. In high school he won a letter in football and played parkboard baseball. Physically, he was a well-built individual, who was 6'2" tall and weighed about 190 pounds.

Possible Implications

Perhaps a good sign of motivation to achieve coming this early in a paraplegic. May also be simply exploration on his part to try to learn if he will be active and productive.

High level of aspiration.

Impulsive, or did not like an academic situation.

A small indication that technical or skilled work might be kept in mind.

Little in service history that helps in job planning.

Low level work experience. Limited by age in amount of experience possible.

Level of aspiration a good deal higher than educational and work experience thus far.

Drastic adjustment to change in physical status is required. Very active person suddenly limited to paralytic status.

May require a good deal of time to accept his radically changed physical capacities. Counseling should not be rushed.

Counseling Developments

The family lived in a relatively good neighborhood. The father was a retired city fireman. The father, brother, and two sisters all had completed high school. Two younger sisters were still in school. The veteran was third in a family of six children.

The patient stated that had he not entered service, he would have gone on to college. In addition to business administration, he mentioned some interest in journalism and in radio repair work.

In the beginning interviews, the vocational counselor noted that the patient seemed intelligent, pleasant, and to have a good command of language, but he seemed not to have accepted the amount of physical handicap his paraplegia would impose. He seemed to be well motivated to achieve at a higher occupational level.

Only limited testing was done during this period of hospitalization since the veteran was discharged with maximum hospital benefits rather soon after counseling began.

On the Strong Vocational Interest Test, he had a primary pattern in the technical group IV occupations. Scores for business-detail occupations were all relatively low, except for an *A* on the Senior CPA scale. On the Kuder Preference Record the highest scores were on the literary, musical, and computational scales, with scores at the 94th, 92d, and 72d percentiles, respectively. There were particularly low scores (15th percentile or lower) on the mechanical, persuasive, artistic, and cler-

Possible Implications

High-level family. Rather well educated.

Family not in financial need with father on pension and operating resort. Parents apparently believe in educating the children.

High level of aspiration again. Skilled-level work admitted as an interest but in last place.

Makes good impression and sounds intelligent. This will help in an otherwise difficult placement problem.

Is need to achieve a personal, family-motivated, or race-motivated need?

No extended counseling possible yet. Unknown yet whether acceptance and understanding of the counseling process are being achieved; patient's expressions of interest may be superficial.

Not a business-administration pattern of interests. Interests plus high-school preferences indicate consideration of technical or skilled trades areas.

Some business-detail interest.

Mechanical area score at variance with strong group IV pattern.

Counseling Developments

ical scales. Since the patient was being discharged, testing and counseling stopped at this point. He was not yet physically ready for work or school but left the hospital knowing that GI Bill or state-sponsored training were possibilities when he felt ready to resume vocational planning.

About nine months later the patient was readmitted to the hospital for treatment of a decubitus ulcer in the area of the sacrum. The ward physician felt that when the ulcer had healed, the patient could work actively and for full days. He would, however, remain limited to wheel-chair status. Since he wished to resume counseling, further interviewing and testing was started. He indicated that he no longer felt an interest in journalism or radio but wanted to explore business occupations further.

On the Army General Classification Test he demonstrated good general mental ability, exceeding 84 per cent of a World War II army inductee norm group. Since he had good general ability and did quite a bit of reading, he was encouraged to take the High School General Educational Development tests. He passed them all and received a certificate of equivalence of high school graduation from the local school board.

After further discussions he decided he would like to try a course in book-keeping. A trial course was given by the educational therapist. Although technical occupational areas appeared to offer more promise for this veteran,

Possible Implications

If he was simply exploring the possibility of ever being productive again, some reassurance was given at this point.

Typical problem for paraplegics.

Patient appears to have a real desire for vocational planning. Not just doing what is expected. On this occasion and the last the patient initiated action to see the counselor.

After being home for a period, the skilled trade has dropped out of consideration. Family may be encouraging higher-level training.

Interviewer's first impressions confirmed. Good general ability.

Patient has now reached educational level of siblings and father.

Certificate may help make ultimate job placement easier. Also opens up wider possibilities for training.

Use of educational therapy as prevocational tryout area.

Maintains high level of aspiration. No mention throughout of racial problems or feeling that he wants to show

Counseling Developments

he continued to reject them and to favor business-college or college-level work.

He took a college-ability test and scored about average for beginning university freshmen. On a test of mechanical comprehension he did better than 69 per cent of a norm group of candidates for apprenticeship training.

After additional counseling interviews the patient decided that he wanted to take an accounting course at the business-college level. He asked, however, what else he might do to investigate college training possibilities. Appointments were made for him to visit two local business colleges and also to have a conference with a university counselor. The patient left the interview affirming his intention to enroll in a business college. He was asked to reconsider the possibilities of technical training of some sort should he become dissatisfied with business training. He was told that he might work further with the counselor should he desire to do so at some future time.

During the course of counseling a Minnesota Multiphasic Personality Inventory was also given. The results would not seem to support the patient's business-detail choice.

The patient was discharged from the hospital. Data were forwarded, at his request, to the university counselor. Follow-up about one year after the last counseling contacts with the patient revealed that he did not enter business college. After talking things over with his parents, he decided to try the uni-

Possible Implications

that his race can achieve. Seems to be no problem here.

Probably can succeed at the college level with his high motivation.

Good understanding of mechanical principles with little school or work background to account for it.

Doesn't give up college aspirations.

Patient allowed to make the choice. Facilities at both training levels put at his disposal.

Probably feels that counselor wants him to go to business college. Goodbye effect?

Seed planted for consideration of area more in line with measured interests. Done as an alternative plan rather than pushed as a first choice.

Smooth transition to the counselor on the academic scene.

Patients like this one need close counselor contacts for both physical and personal problems that will probably arise.

Counseling Developments

versity. He enrolled in a preparatory course for medical technicians. He has satisfactorily completed three quarters of the work and likes college-level training.

He is interested in completing his work as soon as possible and has also registered for the summer session.

Possible Implications

Parents apparently have high-level hopes for the son.

Choice seems like a better one than business administration or accounting. Probably has the ability and motivation to succeed. It should be possible to place him in a laboratory after graduation.

The specific choice was made by the patient, not the university counselor.

Patient E Test Results

Test	Norm Group	Raw Score	T or S Score	%ile
AGCT (AH)	WW II army induc-tees	100	120	84
Ohio State University Psychol. Test (21)	College freshmen	82	48	40
Test 1	" "	20	51	53
Test 2	" "	28	47	38
Test 3	" "	34	48	40
Bennett Mech. Comp. (AA)	Candidates for ap-prentice tng.	42	55	69
High School GED's (B)	High school seniors			
Test 1	" " "	61	47	38
Test 2	" " "	49	56	72
Test 3	" " "	48	59	83
Test 4	" " "	72	65	93
Test 5	" " "	20	46	34

ADULT PROFILE SHEET

• FOR MEN •

For Form BB of the
KUDER PREFERENCE RECORD

(Profile for Women on reverse side)

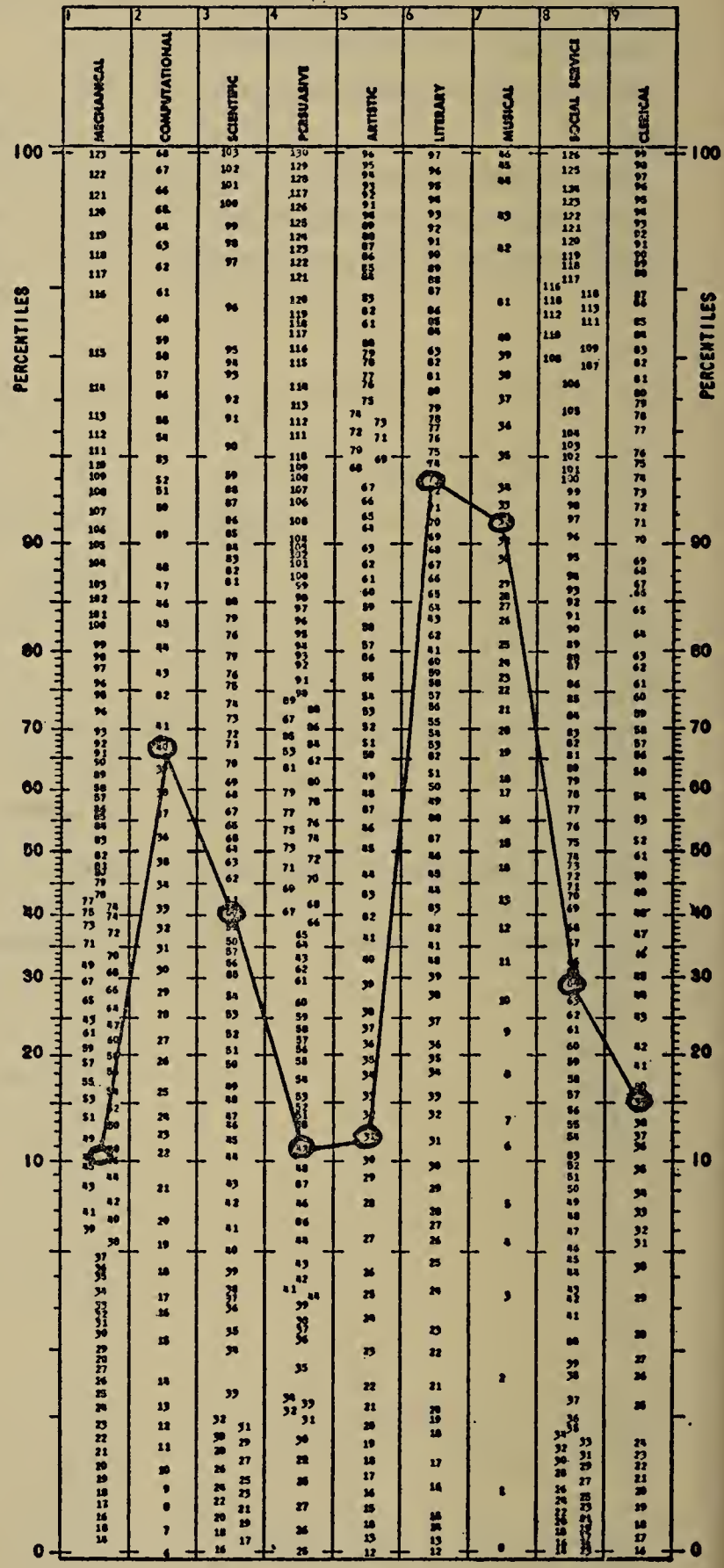
DIRECTIONS

Follow the directions below carefully:

1. Check to see whether all questions were answered. Then detach the answer pad from the test booklet by lifting the pad upward from the binding. ☐
2. Turn the answer pad over to the last page which is marked with the figure 1. Count the number of circles in which holes are punched, starting at the arrow. Do not count the cases in which there are three punches in a circle, since these punches represent errors. In the space for score 1 on the cover of the answer pad record the number of holes you have counted. ☐
3. Follow the same procedure for each of the other scores. Note that scores 2 and 3 are obtained from the same page, and that scores 6 and 7 also come from one page. ☐
4. Obtain the count again for each score, recording your answers in the spaces provided on each page, and compare these scores with those entered on the cover. In cases of differences, make the counts over again until you are sure the scores are right. ☐
5. Enter the nine scores in the space provided at the top of the chart on this page. Men should use the chart at the right; women should use the chart on the reverse side of this sheet. ☐
6. Find the number in column 1 which is the same as the score entered at the top of the column, and draw a line across the column at that point. Do this for each column. If a score is larger than any number in the column, draw the line across the top of the column; if it is smaller, draw the line across the bottom of the column. ☐
7. Fill in the entire space between the lines drawn across each column and the bottom of the chart. The result is the "profile" for this test. The examiner's manual contains suggestions for interpretation. ☐

JOB SUGGESTIONS for MAJOR INTEREST AREAS:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____



STRONG VOCATIONAL INTEREST TEST—MEN

GROUP	OCCUPATION	STANDARD SCALE	C	C+	B-	B	B+	A	70
I	ARTIST								
	PSYCHOLOGIST (REV.)								
	ARCHITECT								
	PHYSICIAN								
	OSTEOPATH								
	DENTIST								
	VETERINARIAN								
II	MATHEMATICIAN								
	PHYSICIST								
	ENGINEER								
	CHEMIST								
III	PRODUCTION MANAGER								
IV	FARMER								
	AVIATOR								
	CARPENTER								
	PRINTER								
	MATH. PHYS. SCI. TEACHER								
	IND. ARTS TEACHER								
	VOC. AGRICULT. TEACHER								
	POLICEMAN								
	FOREST SERVICE MAN								
V	Y.M.C.A. PHYS. DIRECTOR								
	PERSONNEL DIRECTOR								
	PUBLIC ADMINISTRATOR								
	Y.M.C.A. SECRETARY								
	SOC. SCI. H.S. TEACHER								
	CITY SCHOOL SUPT.								
	MINISTER								
VI	MUSICIAN								
VII	C.P.A.								
VIII	SENIOR C.P.A.								
	ACCOUNTANT								
	OFFICE MAN								
	PURCHASING AGENT								
	BANKER								
	MORTICIAN								
	PHARMACIST								
IX	SALES MANAGER								
	REAL ESTATE SALESMAN								
	LIFE INSURANCE SALESMAN								
X	ADVERTISING MAN								
	LAWYER								
	AUTHOR—JOURNALIST								
XI	PRESIDENT—MFG. CONCERN								
	STANDARD SCALE		20	30	40	50	60	70	
	INTEREST MATURITY								
	OCCUPATIONAL LEVEL								
	MASCULINITY—FEMININITY								

NAME

Patient I

AGENCY OR SCHOOL

AGE

DATE

NUMBER

The Minnesota Multiphasic Personality Inventory

Starke R. Hathaway and J. Chamley McKinley

Patient I

Name

Address

Occupation

Date Tested

Education

Age

Marital Status

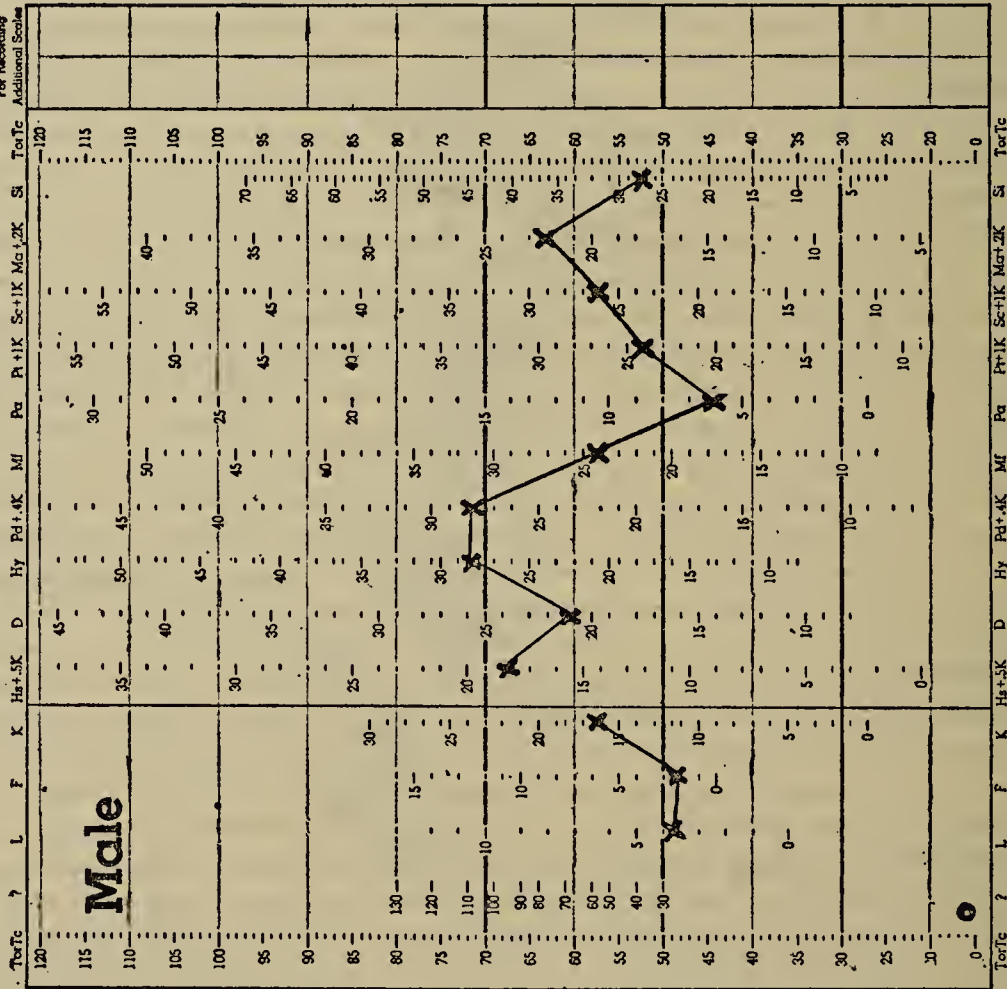
Referred by

NOTES

M
Male

Score's Initials

For Recording
Additional Scores



Percentile of S	1	2	3	4	5
120	100	95	90	85	80
115	95	90	85	80	75
110	90	85	80	75	70
105	85	80	75	70	65
100	80	75	70	65	60
95	75	70	65	60	55
90	70	65	60	55	50
85	65	60	55	50	45
80	60	55	50	45	40
75	55	50	45	40	35
70	50	45	40	35	30
65	45	40	35	30	25
60	40	35	30	25	20
55	35	30	25	20	15
50	30	25	20	15	10
45	25	20	15	10	5
40	20	15	10	5	0
35	15	10	5	0	
30	10	5	0		
25	5	0			
20	0				
15					
10					
5					
0					

Raw Score

K to be added

Raw Score with K

SUMMARY

In counseling with the paraplegic patient a good deal of attention has to be given by the counselor to the patient's reaction to and his acceptance of his very severe disability. The opinion has been expressed that these patients should be seen very early but in a series of short interviews. They should not be pushed into vocational planning before they have had a chance to form a new body image. This may take considerable time, depending, perhaps, on the kind of life adjustment the patient had made before his injury.

The life expectancy of the paraplegic is much longer than it was prior to World War II. Homebound work activity, although it may seem desirable to the patient, is not usually necessary. There is a fairly wide range of jobs the paraplegic can do. Emphasis should be placed on patient participation in the vocational planning and on the development of special skills to facilitate selling the abilities of an otherwise severely and obviously disabled patient to the employer.

Other special considerations in job planning with these patients, such as the need for elevators, ramps, wide doors, and the likelihood of interruptions in employment for treatment of decubitus ulcers and other medical complications, have been discussed. A case study illustrating some of these special considerations in planning with the paraplegic patient was presented.

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- BLOOM, Mildred L., Vocational counseling with the paraplegic, *Voc. guid. Quart.* (Winter, 1953), pp. 46-49.
- KESSLER, H. H., *The principles and practices of rehabilitation* (Philadelphia, Lea & Febiger, 1950), pp. 105, 307-310.

15

The Cancer Patient

PROBLEMS PRESENTED BY THE CONDITION

Advanced cases in this diagnostic category are perhaps among the most difficult encountered by the hospital vocational counselor. Sometimes they will be referred by the ward physician for job-planning assistance, sometimes for therapeutic purposes. On the other hand, they may be voluntary referrals, or the counseling may have started before the diagnosis or the extent of illness is known.

When the vocational counselor is to see patients who have terms such as *carcinoma*, *neoplasm*, *sarcoma*, *metastasis*, *lymphoma*, and *leukemia* in their diagnosis, he should consult immediately with the ward physician and review the patient's chart to determine the extent of the condition, the degree to which the patient is aware of his condition, and just how the counselor can best fulfill his role to the satisfaction of both patient and physician.

An air of mystery, accompanied by feelings of fear, revulsion, and pity, has been common in diagnoses of malignant conditions, and the beginning counselor may find that he has strong feelings along these lines. For this reason, counselors would do well to consider Cockerill's statement (40, p. 193), that "greater familiarity with the nature of cancer, the possibilities for treatment, and the evidences of curability will do much toward helping the worker accept cancer

just as she accepts tuberculosis and heart disease.”¹ Her suggestion that the worker analyze personal equipment for dealing with cancer patients should be given some thought by the vocational counselor. He should examine his personal biases, fears, lack of information, and values in order to see the cancer patient “not as a pitiable victim of a hopeless disease but rather as an individual who is faced by a life situation threatening his security, happiness, and comfort,” and who brings certain strengths and weaknesses to the situation. Cockerill stresses further that there are no special techniques for working with the cancer patient. “Each patient is unique in the problems he brings and the help he desires.”

MEDICAL INFORMATION FOR THE COUNSELOR

The counselor who sees many of these patients will wish to become more familiar with the large field of cancer work and can start by referring to articles in the cancer journals (for example, 94, 118, and 121). However, some of the terms that the counselor might watch for in the diagnosis should be defined here briefly.

Dorland (52) defines a *neoplasm* as “any new and abnormal growth, such as a tumor.” *Metastasis* refers to “the transfer of disease from one organ or part to another not directly connected with it. It may be due either to the transfer of pathogenic organisms or to the transfer of cells, as in malignant tumors.” A *carcinoma* is “a malignant new growth made up of epithelial cells tending to infiltrate the surrounding tissues giving rise to metastases.” *Sarcomas* “are often highly malignant” tumors. A *malignant melanoma* is “a malignant tumor, usually developing from a nevus and consisting of black masses of cells with a marked tendency to metastasis.” A *lymphoma* is “any tumor made up of lymphoid tissue.” *Leukemia* is a “fatal disease of the blood-forming organs, characterized by a marked increase in the number of leu-

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kocytes and their precursors in the blood, together with enlargement and proliferation of the lymphoid tissues of the spleen, lymphatic glands, and bone marrow." The counselor may also work with patients who have Hodgkin's disease, which is a "painless, progressive, and fatal enlargement of the lymph nodes, spleen, and general lymphoid tissues, which often begins in the neck and spreads over the body." These are but a few of the terms in the diagnosis likely to mean that a malignant condition is present in some degree.

The kind and extent of involvement is important information that the counselor should have before his first interview in counseling with the patient. The prognosis is by no means poor for all patients. A patient with a small skin cancer may be left with little or no limitation after treatment. Some rather extensive malignant conditions are surgically removed, and the patient is able to do many jobs after convalescence. Shimkin (121, p. 6), for example, after commenting on some cases where untreated patients lived for years, says, about the period of life before recurrence of symptoms in treated cases, that "cases have been reported of removal of the eye ten to thirty-six years before return of the neoplasm was heralded by the appearance of distant metastases." He says further: "Individual case reports include the appearance of metastases eleven years after orchiectomy for a testicular teratoma, thirteen years after a mid-thigh amputation for osteogenic sarcoma, ten years after nephrectomy for a renal carcinoma, and even a recurrence twelve years after a partial gastrectomy for a gastric carcinoma." Although these illustrations point up recurrence after several years, they also indicate for the counselor that a diagnosis of cancer does not always imply imminent death or incapacity in the immediate future. Years of useful productivity are available in many cases and should be planned for. McGrady (94, pp. 20, 21), reviewing progress of the research sponsored by the American Cancer Society over a ten-year period, states:

Cure rates for cancer have risen steadily. About one of every four patients now are cured. This is the result of improvement in the two standard ways of treating cancer—surgery and radiation. It also is a product of public awareness of the symptoms of cancers and patients reporting to physicians while the disease is still early and presumably curable.

He also points out that although science has not found a drug which will cure cancer, it has found drugs giving excellent palliative effect, so that the problem of pain has diminished.

None of this is meant to imply that cancer is not a serious problem. The intent is simply to caution the counselor to learn about the individual and his particular prognosis and not to assume diagnosis of a cancer condition to be synonymous with hopelessness and death. Even before the cancer-detection program reached its present heights, cancer was given as the second leading cause of death—second only to heart disease in the United States (155, p. 159). It has a higher reported rate for whites than Negroes, probably because of less skin cancer in the Negro and fewer medically reported cases. The highest percentage of cancers in white males is in the digestive tract; in white females, in the genital organs (155, p. 161).

QUESTIONS TO BE RESOLVED WITH THE PHYSICIAN

Following are some questions that the vocational counselor may wish to discuss with the ward physician:

How extensive is the disease? What treatment or surgery is planned? Is the patient aware of his condition? How much does he know of the treatment that is planned for him?

How is the patient accepting his condition? Is he depressed, hostile, aggressive, or suspicious?

How is the condition likely to progress? Is it likely that a cure will be effected? Will the patient leave the hospital?

What organ systems are involved? What physical, dietary,

personal-care, or other limitations are imposed because of loss or damage to certain organ systems?

Should the patient work or train near a medical treatment center? Will he be recalled frequently to the clinic for follow-up?

Is the family aware of the patient's condition? How are they reacting to the diagnosis?

When the patient leaves after treatment, what are the odds for recurrence of the condition? What is the estimated life expectancy in such cases? Are there any things to be observed in trying to obviate recurrence?

Many other questions will arise, depending a good deal on the site and stage of the cancer.

COUNSELING CONSIDERATIONS

Although it may be difficult, it is essential that the vocational counselor feel that the counseling (even in some of the more advanced cases) will terminate in job placement and productive work by the counselee. If the counselor is to seem sincere, counseling must be complete. If the medical diagnosis changes or the prognosis becomes less favorable after the counseling relationship has begun, it is important that this relationship be kept at the same level of intensity throughout the counseling process. Shands *et al.* (118, p. 1170) point out that in the physician relationship, "it is frequently puzzling and distressing to a patient to encounter leisurely sympathy at one visit and brusque matter-of-fact attitude at another." Many of these patients will also be aware of the thoroughness of the interviewing and testing procedures with other patients on their ward and in the vocational counseling service, and they probably will not be easily deceived by token counseling. Moreover, the counselor must remember that even the severe case may live a good deal longer than is expected.

With the cancer patient consideration should be given to the training program that seems to offer him the best chance

to reach full productivity in the field of his choice as quickly as possible. Some patients will be anxious to become productive at a qualified level as soon as possible, not only because of a possible feeling that their time for productivity is shortened but because their illness has often seriously depleted their savings. The probability that a long training program will be a financial loss to the agency should be considered only when it is obvious that the patient has an extremely short life expectancy.

If the patient is contemplating training and the treatment has left him with physical limitations, or if it is known that he will slowly become progressively weaker, careful attention should be given to anticipating whether or not he will be able to handle the more difficult and advanced aspects of the training. He should not later be placed in the position of not quite being able to finish. It is possible usually to set up restricted-activity training programs. Cutting out certain activities in a training program has to be done sparingly, however. Nothing is achieved if the program is tailored to the extent that the patient is not employable in his specialty after the training is completed. Since public abhorrence of cancer diagnoses and the possible physical unattractiveness of the patient may make placement difficult, it seems wise to plan well below anticipated physical-capacity levels in severe cases. Rather than tailoring more demanding occupations, training in additional skills at lower physical-demand levels may make the patient more salable and less likely to experience personal frustration.

These patients often seek additional medical information about themselves and may try to get such information from the counselor. They may look for meanings and implications about their conditions in just about everything the counselor says and does. Some of the references in this area indicate disagreement among medical men about how much the patient should be told. Certainly it is not the counselor's place to tell the patient about his condition.

Shands *et al.* (118, p. 1169) express the feeling that it is "impossible to make any general statement about the amount of information that all patients should be given. Specialists in the cancer field differ in opinion all the way from one extreme to the other." They do feel, however, that the patient should be told nothing until definite histological diagnosis has been established. The projected program of treatment in any of several eventualities is outlined. The patient ordinarily is not informed of more of the situation than he asks to know about. After the physician decides what the patient should know, he tries to allow him to arrive at his own conclusion in his own way (118, p. 1170). It is not the counselor's job to impart this medical information to the patient. To work intelligently, however, he has to know the physician's plan in this regard, the extent of the patient's knowledge, and his acceptance or rejection of this knowledge.

Upham (155, p. 161, 162) describes a cancer service where the disease was talked about freely with patients on the ward and in the clinic. She states that "the disease, for these patients—lost much of its hidden fearfulness and all developed great confidence in the doctor." She also feels that "much of the fear of cancer possibly stems from the conspiracy of silence surrounding it." The counselor's concern should be to know and become part of the team approach to the particular patient. Were he to avoid discussion of the disease with a patient who knew and had accepted his diagnosis and treatment, he might well create new anxieties and fears in the patient. The patient also might well have difficulty establishing more than a superficial counseling relationship with a counselor who appears evasive or deceptive.

The physician's decision on how much the patient should know will be based on the particular patient's ability to bear the truth. Cockerill (40, pp. 193, 194) expresses this when she states that "it is just as necessary for some patients as it is harmful for others to know the truth." Her admonition to the social worker is applicable also to the counselor: "It

is important that the worker should not confuse her own needs with those of the patient when she is attempting to arrive at a decision." The counselor can be very helpful to the physician in giving him an evaluation of the patient's present and possible future level of personality adjustment.

It also seems important for the counselor to know how completely the family has been informed of the patient's status, since, in counseling, it is often valuable to see wives and other relatives. The physician or social worker generally will have informed the patient's family in cases with a terminal prognosis. In these terminal cases, false hopes may be aroused for the family if the basis for the counselor's activity is not known to the social service worker and, through her, to the family.

The two-year psychiatric pilot study by Shands *et al.* (118, pp. 1159-1170) on the emotional reactions of cancer patients seen at the Massachusetts General Hospital should be read by counselors working with cancer patients. Examples of patients with such reactions as depression, aggression, and guilt feelings are given. The following quotations from the study seem important for counselors to consider:

The immediate distress observed in patients suspecting or knowing of a malignant lesion is to be understood in large part as the result of a sudden, severe, shift in the patient's system of estimated probabilities of survival, degree of comfort, future group relationships, and so on. . . .

Psychological mechanisms employed in "processing" information about a malignant lesion are identical with those observed in other situations in which individuals are confronted with unpleasant information about themselves. The defense mechanisms are identical with those observed in psychoneurotic patients.

Some specific things the vocational counselor might do are:

Try to become as intensely involved in the counseling process with these patients as with the heart, tuberculosis, and other patients. Try to avoid allowing your own fears and stereotypes of cancer to become confused with the patient's

reactions. If the patient's appearance bothers you, it might be best to transfer his case to another counselor.

Avoid terminating the counseling relationship if the patient becomes aggressive. He may not be able to express his fears in any other way (1, p. 204).

Consult the physician as early as possible after referral of such patients.

Avoid token counseling. If the patient really wishes to participate, the counseling work-up and interviews should be as complete as for any other patient. Remember that except for very advanced cases, the probable life span is not really known.

Be a good listener. The patient "may need an objective, interested person with whom he can counsel and to whom he can relate his feelings. It is difficult for him to secure this relationship elsewhere, because his relatives are frequently distraught and hysterical, his friends full of conflicting and confusing advice" (40, p. 196).

Be informed of medical and surgical consequences, like colostomy, facial disfigurement, plastic surgery, and orthopedic limitations, and some of the adjustments and prosthetic corrections that may be possible. Except in cases with short life expectancy, the counselor will not be concerned so much with the limitations of cancer as with those imposed by the patient's reaction and those imposed by the required treatment procedures.

Continue actively with patients in the terminal stages of their illness for the therapeutic value it may have both for the patient and for ease of hospital management of the patient. As Abrams (1, p. 208), writes "rejection of patients in the terminal stage of their illness is a common reaction. Many of us unwittingly reject what we cannot cope with effectively." ²

Cancer patients usually are hospitalized for fairly long periods, and attempts are made to interest them in things

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other than preoccupation with their disease. The counselor can make much use of educational, occupational, and manual arts therapy, library facilities, and special services with these patients and thereby gain valuable prevocational information. The counselor is in a particularly good position to help give direction to the patient in making the best use of these activities. If several patient activities are directed toward the assumption that he will be productive again, as in vocationally directed occupational therapy, marked changes in patient attitude toward hopefulness are sometimes seen.

Start work on placement early in the recuperation period. Attitudes toward cancer and possible disfigurement may require longer and more intense placement effort. Having the placement man meet the patient in the hospital may both motivate the patient and help to cushion the awkwardness of the meeting in a new environment after discharge. In addition, if the placement specialist really has a chance to get to know the patient, he may be better able to control his own biases about cancer and make a more realistic effort in the patient's behalf. Unnecessary delay in placement after the patient has been discharged from the hospital, in some cases, may well serve to confirm the patient's feelings of inadequacy and rejection by society in general.

It is likely that these cases have been somewhat neglected by the busy case-hardened hospital vocational counselor. If he will stop to look into their needs and to examine his own concepts of cancer, he will probably find patients in need of his services who will provide some of the most challenging and interesting problems he will be called upon to meet.

ILLUSTRATIVE CASE STUDY

The case study that follows presents a rather typical case of Hodgkin's disease in a young man. Although the patient expired before completion of his planned training program, it is felt that the counseling process helped give purpose and direction to the patient's remaining months. The patient was aware of his condition, apparently needed the support of the

counselor, and possibly avoided becoming a personality problem for the treatment team by participating in vocational planning and training. The case study also indicates the need for continuing counseling, when the patient desires it, even when the prognosis becomes very poor.

Patient F: Hodgkin's disease; age, 21; modal prior occupation, college student.

Counseling Developments

This twenty-one-year-old, white, male veteran of the Korean period came to the vocational counseling service, without medical referral, to request assistance in planning vocational training. He had been diagnosed four months earlier, on the basis of cervical node biopsy, as having Hodgkin's disease. This was his first admission to the hospital, although he had been treated with X ray in a service hospital prior to this admission. A repeat biopsy confirmed the diagnosis of Hodgkin's disease.

The patient stated that he was aware of his diagnosis and its severe implications. He obviously felt, however, that he had quite a few years left. He did not seem depressed or preoccupied with his physical status. He was retired from the service, and it was apparent that he would be receiving a service-connected disability allowance.

The patient was married and his wife was employed as a saleslady. He and his wife rented an apartment in a large city near the hospital. He indicated that he had no outstanding financial obligations.

The counselee had eligibility for about a year and a half of GI Bill

Possible Implications

Self-referral may indicate a real desire to participate in vocational planning or a need to talk with a person not immediately involved in his physical problems.

Serious physical condition with an ultimately fatal prognosis.

Firm medical diagnosis. No place, however, for the vocational counselor to assume that planning might be wasted time because of the medical prognosis.

Good patient attitude, since he might, in fact, live many years with this condition.

Either emotionally well adjusted and intelligent enough to understand his condition or making every effort to avoid thinking about it.

No apparent financial or social problems.

Training costs will not be a burden for the patient.

High level of aspiration.

Good basic education.

Probable high-level family background.

Desire to explore areas

Counseling Developments

training and would be eligible for four years of rehabilitation training after adjudication of his claim for a service-connected disability. Although the patient had not trained before under VA sponsorship, he had completed about one year of prewar art training in a small college. His high school training had been completed in American and English schools overseas, where his father had been a missionary for several years. He felt that he had received good training in these foreign-mission schools but had felt restricted by their limited course offerings. A check on previous college work indicated that the patient's appraisal of just average grades was correct.

Since the patient was only twenty-one years of age, had served in the Navy, and had completed about one year of college, work experience was limited to relatively short-time jobs of an unskilled nature. He had done general labor work for a power company for five months, worked as a shipping clerk for about five months, and worked as a press operator in a can factory for about four months.

Service experience of about eleven months in the Navy included four months of sea duty (not in combat). He was not in service long enough to achieve special skills or advanced rank. Hospitalization for the present medical condition began while he was still in service.

After fact-gathering interviews the vocational counselor felt that the pa-

Possible Implications

where he can do individual thinking.

Honest about his achievements—not trying to impress the vocational counselor.

No time for extensive work experience.

Jobs held were below level of ability and aspiration and were temporary expedients of little significance for present planning.

Service experience not helpful in vocational planning. No indications of inability to adjust to the service experience.

Makes a good impression on a relative stranger. At ease

Counseling Developments

tient was a very bright individual, who met people well, expressed himself well, used good diction, and presented a good personal appearance. He seemed to have made a good emotional adjustment to his knowledge of his disability, discussing it freely but not often.

Expressed interests, although rather vague at this time, were for additional college-level training in the more verbal areas. Measured interests on the Strong Vocational Interest Test showed rather good agreement with those of successful persons in the social-service occupations. There was also a primary interest pattern in the technical or trades area.

Other test results indicated excellent general mental ability, on the Army General Classification Test (AH), when compared to World War II inductees, and average college aptitude when compared to a university freshman norm group. Ability to understand mechanical principles, as measured by the Bennett Mechanical Comprehension Test (AA), was excellent when compared to a group of candidates for apprenticeship training in the skilled trades. This score also held up well when compared to scores of engineering freshmen. Ability to do routine clerical tasks involving speed and accuracy was above the average of employed men but fell considerably when compared to employed male clerical workers.

The patient was not surprised at his high test scores, apparently knowing that he had high-level ability. After

Possible Implications

in interpersonal situations.

Apparently really has accepted his physical status.

Wish to achieve at the college level and to explore more areas than the high-school experience permitted.

Measured interests suggest consideration of social-service type occupations. Expressed interest for college-level work is borne out by primary interest pattern.

Considering father's occupation and patient's background, it is surprising to note interests in the skilled-trades area.

Confirmation of vocational counselor's interview impressions. Has not been working up to his level of ability. Illness may be a reason, since he seems to have been ambitious.

High-level abilities offer him a wide choice of training objectives.

Aware of ability but wants help in directing his efforts.

The interest testing was

Counseling Developments

going over interest test results, he asked for more information on fields like teaching, political science, history, and social work. He said he had once given some thought to the foreign service area. He was not interested in the ministry, feeling that he had no special urge for this kind of work. He was given occupational descriptive and outlook materials and school bulletins for local college-level institutions to read over in his spare time on the ward. He seemed the kind of individual who liked to do his own exploring after being given tentative leads.

Consultation with the ward physician at this point indicated that further therapy was not planned during this hospitalization and that the patient was to be discharged from the hospital. It was felt by the physician that aside from doing very heavy work, he should not be considered as having any physical limitations. It was, in fact, considered desirable that he live as normal a life as possible. Although ultimate prognosis was not good, it was not possible to estimate the number of months or years that would elapse before the patient had a more severe exacerbation of his condition. On this basis the vocational counselor felt the patient should not be limited in his planning for training because of the seriousness of his condition.

After additional evaluation interviews the patient decided to enroll again in the college he had attended before the war. He planned to prepare for social science high school teaching

Possible Implications

probably most helpful for him.

Good tentative selections. Patient is making the choices.

Good patient participation should obviate possibility of too much dependency on vocational counselor in making final decisions.

Within the framework of this patient's interests, and with his lack of financial problems, his physical condition is not limiting at this time.

Imposition of physical restrictions by the counselor would serve only to increase anxiety.

Life expectancy not known.

Good decision. Length of course not considered important, since no one can predict progress of the disease at this point.

Counseling Developments

and hoped to include as many history, political science, and social work courses in his curriculum as possible. He left the hospital, received a service-connected disability award, and enrolled in college as a rehabilitation trainee.

It was felt by the vocational counselor that the patient would be satisfied with his courses, would do satisfactory college work, and would not have social or financial problems. The final physical picture was not bright, but there was the possibility of several productive years.

About three months later, the veteran interrupted his training and was readmitted to the hospital. Because of rapidly enlarging lymph nodes he was given a course of nitrogen-mustard therapy. He was admitted again in about another three months for another course of therapy, after developing a generalized pruritis. He was admitted again after another short period because of progressive enlargement of the lymph nodes and development of edema. During these hospitalizations he was not active with the vocational counselor. After another course of therapy he was discharged from the hospital and returned to school.

About four months later the patient returned to the vocational counseling service to indicate that he was coming into the hospital again. He requested that we inform his training officer of this so that his return to training after discharge would not be impaired. He had made satisfactory progress in his

Possible Implications

No active role for the vocational counselor, since patient did not feel well enough.

Patient's course should still be followed, since the rapport of the previous counseling relationship is useful in some cases to help build morale or motivate patient activity. This was not necessary with this particular patient.

Patient still had motivation for further training after re-hospitalization.

Perhaps reassuring himself. Becoming more concerned over his physical condition.

Good motivation.

Beginning to have true insight into the seriousness of his condition.

Counseling largely suppor-

Counseling Developments

additional college work and liked it, even though his studies had been interrupted frequently by illness.

The patient did not seem to have given up but did want reassurance that he could return to training when physically able to do so. He indicated that he was to start a new course of therapy and that there might be some doubt that he would survive. He did not wish to participate in further vocational counseling, indicating that he was satisfied with his present vocational plan.

About one month later the patient expired.

Possible Implications

tive at this point. Counselor has a moral obligation to continue, although odds are now great that there will be fatal outcome of the disease in the immediate future.

Patient experienced some sense of achievement during the progressive course of his disease. Relatively rapid progress of disease was not predictable when counseling started.

Patient F Test Results

Test	Norm Group	Raw Score	T or S Score	%ile
AGCT (AH)	WW II army induc-			
	tees	131	146	100
"	College freshmen	131	146	99
Ohio State University				
Psychol. Test (21)	College freshmen	101	52	58
Test 1	" "	24	59	82
Test 2	" "	39	54	66
Test 3	" "	38	51	54
Bennett Mech. Comp. (AA)	Candidates for ap-			
	prentice tng.	56	74	99
" " "	Engin. Freshmen	56	63	90
Minn. Clerical Test—Nos.	Employed men	98	56	71
Minn. Clerical Test—Names	" "	129	64	92
Minn. Clerical Test—Nos.	Male clerks	98	36	8
Minn. Clerical Test—Names	" "	129	51	54

STRONG VOCATIONAL INTEREST TEST—MEN

GROUP	OCCUPATION	C	C+	B-	B	B+	A		
	STANDARD SCALE	0	10	20	30	40	50	60	70
I	ARTIST								
	PSYCHOLOGIST (REV.)								
	ARCHITECT								
	PHYSICIAN								
	OSTEOPATH								
	DENTIST								
	VETERINARIAN								
II	MATHEMATICIAN								
	PHYSICIST								
	ENGINEER								
	CHEMIST								
III	PRODUCTION MANAGER								
IV	FARMER								
	AVIATOR								
	CARPENTER								
	PRINTER								
	MATH. PHYS. SCI. TEACHER								
	IND. ARTS TEACHER								
	VOC. AGRICULT. TEACHER								
	POLICEMAN								
	FOREST SERVICE MAN								
V	Y.M.C.A. PHYS. DIRECTOR								
	PERSONNEL DIRECTOR								
	PUBLIC ADMINISTRATOR								
	Y.M.C.A. SECRETARY								
	SOC. SCI. H.S. TEACHER								
	CITY SCHOOL SUPT.								
	MINISTER								
VI	MUSICIAN								
VII	C.P.A.								
VIII	SENIOR C.P.A.								
	ACCOUNTANT								
	OFFICE MAN								
	PURCHASING AGENT								
	BANKER								
	MORTICIAN								
	PHARMACIST								
IX	SALES MANAGER								
	REAL ESTATE SALESMAN								
	LIFE INSURANCE SALESMAN								
X	ADVERTISING MAN								
	LAWYER								
	AUTHOR—JOURNALIST								
XI	PRESIDENT—MFG. CONCERN								
	STANDARD SCALE	20	30	40	50	60	70		
	INTEREST MATURITY								
	OCCUPATIONAL LEVEL								
	MASCULINITY—FEMININITY								

SUMMARY

In this chapter much emphasis has been given to the importance of the vocational counselor's attitudes toward cancer conditions and cancer patients. Some of the literature on cancer, from medicine and from the social work area, has been cited which should give the vocational counselor some familiarity with the nature of cancer and enable him to examine his own personal biases, fears, and lack of information about cancer. It has been stressed that the cancer patient should not be looked on as a pitiable victim of a hopeless disease. Years of useful productivity are available to the patient in many cases.

Some specific points that the vocational counselor might consider have been listed, including the following important points:

1. Avoid token counseling with these patients.
2. Maintain the intensity of the counseling relationship, even if the prognosis becomes poorer than it was at the start of the counseling relationship.
3. If the patient's physical appearance bothers the counselor, arrange to have another counselor take over the case if possible.
4. Be a good listener. The counselor may be the only objective, interested person to whom the patient can talk.
5. Attention should be given to careful job planning, perhaps below the level of present physical capacities, that will, if possible, anticipate future limitations likely to result from further treatment or the progression of the condition. Careful planning with the physician is necessary with regard to both the area of physical limitations and the patient's emotional reactions to the disease and the treatment plan.
6. Special skills should be taught, if possible, to make the patient more saleable to an employer, and placement efforts should begin early because public attitudes toward cancer and possible disfigurement of the patient may make these patients very difficult to place in jobs.

A case study including vocational counseling problems and procedures with a patient who had Hodgkin's disease was presented to illustrate the points discussed in the chapter.

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16

The Skin Patient

PROBLEMS PRESENTED BY THE CONDITION

Vocational counseling with the patient who has a fairly severe dermatitis is often difficult. There are many possible causes of dermatitis and individual susceptibility varies greatly; therefore, the patient is likely to have a long course of hospitalization and treatment and may become rather discouraged about his progress. He usually presents a poor physical appearance, may be very sensitive about it, and is apt to look physically worse off to his friends and to potential employers than is actually the case. He is also apt to have been advised to avoid so many conditions and exposures to irritating agents or possible causative agents that placement in work or training, at first, may appear to be impossible.

Bridges (31, p. 64) cites dermatitis as the most frequent type of disabling occupational disease. In 1943, Schwartz (116, p. 299) stated that records show that about 70 per cent of all reported occupational diseases in the United States are dermatoses. Since the dermatitis may often appear to have been caused by occupational conditions, it is fairly typical for the patient and the counselor to be faced with the necessity for planning complete occupational change, often with little possibility of utilizing past experience.

MEDICAL INFORMATION FOR THE COUNSELOR

Dermatitis is defined by Bridges (31, p. 64) as "the general term applied to those effects, which include redness, irritation, eruptions, blistering, weeping of the skin, pimples, or

boils, etc. Dermatitis may be mild or very severe, acute or chronic, immediate or delayed, localized or general.”¹ Another term the counselor will hear used is the *dermatoses*. These are defined by Schwartz (116, p. 296) as follows: “under the name of occupational dermatoses are included stigmata, injuries, ulcerations, inflammations, and proliferations of the skin, caused by contact with substances encountered in the course of occupation.”

The dermatologist uses a number of descriptive medical terms. Following are a few terms, taken from Dorland (52), that the counselor may see in the diagnoses of skin conditions of patients referred to him:

Acne Vulgaris: “common acne, a chronic inflammatory disease of the sebaceous glands, occurring most frequently on the face, back, and chest.”

Atopic dermatitis: “allergic eczema.”

Contact dermatitis: “dermatitis venenata—an acute allergic inflammation of the skin caused by contact with various substances of a chemical, animal, or vegetable nature.”

Erythema: “a morbid redness of the skin of many varieties, due to congestion of the capillaries.”

Folliculitis: “inflammation of a follicle or follicles (follicle—a very small excretory or secretory sac or gland).”

Keratosis: “Any horny growth, such as a wart or callosity; any disease attended by horny growths.”

Lichen planus: “an inflammatory skin disease with wide flat papules, often very persistent and occurring in circumscribed patches.”

Melanosis: “a condition characterized by abnormal pigmentary deposits.”

Mycotic dermatitis: “dermatitis caused by yeast infections.”

Seborrheic dermatitis: “an inflammatory disease of the skin characterized by yellowish, greasy scaling of the skin of the scalp, midparts of the face, ears, and supraorbital regions, and usually accompanied by itching.”

This very brief reference to general diagnostic terms gives some idea of the terminology used and the range of condi-

¹ By permission from *Job placement of the physically handicapped*, by C. D. Bridges. Copyright, 1946, McGraw-Hill Book Co.

tions the counselor will meet. Persons doing much counseling with skin patients will get a more complete idea of the terminology, range of conditions, and large amount of work being done in the field by consulting such references as those by Sulzberger and Wolf (129) and Sulzberger and Baer (128). The etiology and treatment of skin diseases is a complex field which has been studied intensively for many years. Those who believe that the problems of the dermatologist are rather recent should consult Schwartz (116, pp. 296–299), whose short but informative history of skin disease goes back to the 1500's.

Writers in the field of dermatology (for example, 116, p. 320, and 129, p. 529) caution against placement of dermatitis patients in conditions where they will be exposed to irritants. Bridges (31, p. 64) states that "the principal physical conditions that dictate against placement in a known skin-irritant exposure are existing skin disease or a history of frequent skin disorders."

Although the vocational counselor is not active in diagnosis and treatment of these patients, he may be able to contribute useful information to the physician in the course of developing complete counseling data. He will want to know something of the general facts of causation to be able to learn about his individual patient from the doctor and to avoid very obvious placement mistakes after counseling has been completed. Some generalizations that apparently can be made about skin diseases follow.

Chemicals are an important cause of industrial dermatitis. Some principal causes of dermatitis are alkalies, cleaners, soaps, petroleum products, solvents, cutting oils, coolants, chromic acids, chromates, metals, metal plating, plants, dyes, acids, rubber, compounding ingredients, and resins (31, p. 64). Many skin diseases can be traced directly to occupational, hobby, or activity factors: for example, acne and furunculosis in workers exposed to such agents as oils, tars, or chlorine; and eczematous or mycotic eruptions in wash-

women, housewives, soda dispensers, dyers, tanners, and rubber workers (129, p. 3). Schwartz (116, p. 300) lists the principal actual causes of occupational dermatoses as petroleum oils and greases, alkalies (including cement and concrete), solvents, chromic acids, metals (including metal plating), dyes, plants, rubber, rubber compounds, paints, varnishes, and synthetic resins. A recent comprehensive study of skin conditions that will give the counselor background in this area has been written by Allen (2).

The Negro is less susceptible to the action of skin irritants than the white man (31, p. 64 and 116, p. 301). Blond races are more susceptible to some irritants. Oily skins tend to develop acne. Dry skins are most readily affected by solvents. Applicants who have dry skins should not be placed at jobs where they must immerse their hands in fluids which defat the skin, such as strong soaps, alkaline solutions, or the volatile solvents (116, p. 320). For persons with dry skins, cleansing of affected areas with soap or other irritating or drying detergents should be reduced to a minimum (129, p. 529).

Perspiration is a factor to be considered in the job planning of a dermatitis patient. It is pointed out that although perspiration is normally a protective agent which dilutes irritants, it also renders the worker more subject to irritation from substances that need moisture to make them irritants (116, pp. 302, 303). Moisture may also foster the growth of fungus conditions (129, p. 233). In addition, perspiration and hot weather usually lead to the wearing of less clothing, making contacts with skin irritants more likely to occur (116, p. 303).

Age is another factor to be discussed with the physician in planning since writers point to the fact that chronic types of dermatitis usually occur in or beyond middle age and that older persons generally have a greater capacity to withstand skin irritation (31, p. 64 and 116, p. 303).

Personal cleanliness and cleanliness of the work environment are important factors. Good ventilation of the work

environment and the use of exhaust fans and protective clothing may be helpful.

QUESTIONS TO BE RESOLVED WITH THE PHYSICIAN

With this brief background, the counselor may wish to consult with the dermatologist along the lines of some of the following sample questions:

Does the patient appear to have a chronic dermatitis, or is his condition probably temporary?

Is the patient co-operative in the management of his condition? Can the counselor contribute to his acceptance of the need for care?

Must the patient avoid exposure to the elements? Is a change in climate advisable and realistic for this patient?

Is perspiration due to physical exposure or exertion a factor for this particular condition?

Are there specific substances with which the patient should not come into contact, such as gasoline, oils, solvents, cement, or turpentine?

Is the skin condition a reaction to another medical condition which, in itself, imposes certain restrictions on physical activity?

Does there seem to be an appreciable psychosomatic factor involved? Is psychotherapy in order with the patient?

Are there specific allergies involved which might make such things as factory dust, sawdust, woods, greenhouse plants, or irregular restaurant diets important for this patient?

COUNSELING CONSIDERATIONS

Obviously there are many things to consider with the skin patient. The counselor will have to concern himself with careful analysis of the situation of the individual patient, in consultation with the physician, and will be especially concerned with detailed examination of the duties and exposures involved in the kinds of work considered during the

counseling. One writer gives a useful list of fifty-seven general occupations with their principal dermatological hazards and possible preventive measures (116, pp. 336–340).

In addition to careful attention to exposures and irritants, the counselor will be concerned with some patients who are suffering from neurodermatitis. Strecker *et al.* (124, p. 421) state that “the skin often serves as a medium of emotional expression. The so-called neurodermatitis cases are among the commoner psychosomatic disturbances.”² Yacorzynski (176, p. 83) states that “underlying emotional factors have been frequently mentioned in allergies and skin disease. It is recognized that in neurodermatitis emotional factors are likely to precipitate the outbreak of the dermatitis.” The counselor will want to be alert, then, to emotional and personality factors, frustrations, and situations of life stress. A word of caution is in order here lest the counselor “write off” too many patients referred to him as cases of neurodermatitis. His role is not that of diagnostician but of consultant with the physician, who will know a great deal more than he does about the many other possible causes of the skin condition. Many patients with very real chemical or other demonstrable causes for dermatitis also have maladjustments which may tempt the counselor to think in terms of psychotherapy at the expense of careful job placement.

In vocational counseling with the skin patient the taking of a very complete occupational, hobby, and activities history is particularly important. This will permit contribution of useful information to the physician and will also make job placement easier. It will be important to know such things as how heavy each job was, what working conditions were like, what the patient was exposed to in the way of irritants and work stresses, and how satisfied he was with his jobs. In some cases readjustments in the former job or an allied one can be made if specific irritants are removed.

² By permission from *Practical clinical psychiatry*, by E. A. Strecker, F. G. Ebaugh, and J. R. Ewalt. Copyright, 1951, Blakiston Div., McGraw-Hill Book Co.

Since the patient may have to avoid many conditions in making his occupational readjustment, considerably more testing and interviewing may be done than is usual with most patients, to tease out as much special aptitude and achievement information as possible. Interest and personality factors will be important areas for careful measurement in the attempt to find working conditions compatible with the patient's personality make-up. Trade testing may be very useful to establish present levels of competence in past jobs and allied fields to which he might find readjustment easier.

Since physical appearance, even after treatment, may be disfiguring, these patients may well need more help in making initial employer contacts than the average patient. It is also important that the counselor feel at ease in working with the particular skin patient, even though he does not present a very good physical appearance. He will probably already have become sensitive or bitter about his appearance after rebuffs in seeking employment or after hearing chance remarks of friends and other patients. If the counselor feels ill at ease, he will be doing both the patient and himself a service by having another counselor undertake the actual counseling process.

ILLUSTRATIVE CASE STUDY

The following case study should serve to illustrate some of the typical problems, such as physical limitations, poor appearance, questionable emotional adjustment, and need for placement assistance, that are encountered in vocational counseling with patients who have dermatitis.

Patient G: eczema, hands and legs; age, 50; modal prior occupation, personnel-section interviewer.

Counseling Developments

The patient is a fifty-year-old, white, male veteran of World War II, who, having heard of the vocational counseling service from another patient, came

Possible Implications

Self-referral may indicate sincere desire to participate in vocational planning. Could also mean satisfying himself

Counseling Developments

to the counselor without formal referral. He indicated that he was unemployed and needed job-placement assistance urgently, since he was leaving the hospital in about ten days. He had a wife and seven children (the eldest only eleven years of age) to support. He also wished to move to a larger city, feeling that he had exhausted employment opportunities in the small town where he had been living. His home is in an adjacent state.

The patient had a service-connected disability for an old ulcer condition, but in an amount of less than 10 per cent, and was not drawing disability compensation. The skin condition was not service connected. He had no eligibilities for VA-sponsored training but had previously trained, under the GI Bill, as a tailor, hoping to take over his father's tailoring trade.

Consultation with the ward physician indicated that the patient was being treated for eczema of the hands and legs. The physician felt that the patient could work if he wanted to but that his condition might still take some time to clear up. He was to work at relatively clean jobs and was to avoid cotton, wool, silk, horsehair, soaps, and water. Office types of work were felt most desirable from a medical viewpoint. There seemed to be some question of the patient's motivation to work.

Personal appearance was relatively poor. In addition to the eczema, the patient did not look very clean. He had a habit of getting very close to one while talking (in a sort of confidential

Possible Implications

that he had made the socially expected effort to find employment.

Social service referral probably desirable. Large family may be more difficult to support in a larger city.

Are employment opportunities really exhausted? Does he wish to get away from present social and family environment?

If training is desirable, state assistance will have to be requested.

Investigate reasons for leaving the tailoring trade.

Eczema on hands will be obvious to potential employers.

Some doubt of patient's expressed desire for work.

Physical condition greatly limits job-placement possibilities. Some kind of clerical work may offer most promise.

May be necessary to talk to patient about acceptable personal appearance when applying for jobs.

Offensive appearance and manner of talking to others.

Counseling Developments

fashion). Although his street clothes were acceptable, they were not well pressed or clean. The vocational counselor noted that personal appearance would be rated below average, even with the eczema cleared up.

The patient's father was a tailor who learned his trade before coming to this country and apparently had been successful. The patient was an only son in a family of three children. One sister completed high school and business college and then married; the other completed high school plus three years of college and is now married. The patient completed eleventh grade in school and one year of business college. He said he left school because he wanted to get an early start in a business job.

It developed in the interview that the patient and his wife were not getting along well. He seemed to like his children and has a strong attachment to his eleven-year-old daughter.

Prior to his Navy service the patient worked for about five years as an interviewer in the personnel section of a state agency (leaving he said because of "political friction"); about two years as a sales clerk in a small clothing store (leaving for higher wages), and about eight months as an apprentice tailor (leaving because of allergies to the material used).

After military service he worked for two seasons as a second cook on lake boats and about five months as a self-employed operator of a small restaurant (leaving because of irritation from

Possible Implications

Patient has not achieved as much educationally as his siblings.

May have been favored or sheltered at home as an only son among three children.

Ability or lack of motivation may also have entered into his decision.

May be a reason for desire to move to the city.

Preservice work history is fairly stable. Seems to have had good reasons for job changes.

PostsERVICE work history is spotty and erratic. Age on discharge from service might have made vocational readjustment with his level of training fairly difficult.

Variety of jobs. Apparently took whatever work was available—growing family responsibilities.

Seems to want to get into

Counseling Developments

soaps and water and because business was slack). He also worked for short periods of time as a coal passer, a grader of wooden door panels, a book-keeper, and a receiving clerk. Of all his jobs, he said that he liked clerical work the best.

Service experience was not very useful in occupational planning since it consisted of only about seven months as a seaman, doing general duty. He was discharged early on the basis of age.

Reading habits were limited to magazines, primarily detective stories. He had no active hobbies but liked to fish.

Expressed interests were for clerical work or factory inspection or checker jobs. Measured interests on the Kuder Preference Record were highest in the social service, clerical, and computational areas (all above the 80th percentile). Scores were low for the artistic, musical, scientific, and mechanical occupational areas. The Strong Vocational Interest Test was not given.

Other test results indicated above-average general mental ability when compared to World War II inductees, on the Army General Classification Test (AH); above-average ability to do routine clerical work when compared to employed men; good ability to work with spatial relationships when compared to World War II males; and arithmetic ability at about the ninth-grade level.

No personality testing was done, since the counselor felt the patient was exhibiting little more than normal anxiety over the support of his family and little time was available to com-

Possible Implications

the job area most compatible with his disability.

Nothing that might contribute to vocational planning now.

Relatively low level in avocational activities. Large family on a low budget may have precluded many hobby and social activities.

Expressed and measured interests agree with preferred job and with modal prior occupation. Also compatible with physical and environmental limitations. Not very compatible with appearance and manner, however.

A good deal of the time, in service and out, patient has worked below his level of ability.

Some mechanical aptitude but no expressed, measured, or demonstrated interests in this area. Interests do not indicate jobs like drafting, although he might be able to do such work. This might be suitable for both physical condition and appearance.

Personality testing might have been valuable, since the onset of the skin condition,

Counseling Developments

plete vocational planning and to find at least temporary job placement.

A check with the social worker indicated that the patient's family was receiving ADC assistance in the home county. The social worker questioned the patient's sincerity in his expressed desire to find work, since he had been a problem for some time in the home community. The possibility of a neurodermatitis was also suggested.

After evaluation interviews with the patient, it was decided that age, education, personal appearance, and recent job experiences all made the likelihood of satisfying social service interests in personnel work or interviewing unlikely. Clerical occupations seemed most compatible with disability, interests, and abilities. Age and appearance would still create a placement problem, however, and it was decided, by the patient and the vocational counselor, that it might be wise to investigate civil service clerical opportunities. This was done and patient took an examination

Possible Implications

the development of large family responsibilities, and the unstable postwar work history all developed during the same general period. The past history of an ulcer condition might also enter in.

Some of the patient's financial responsibilities are temporarily relieved.

Having the family on county aid in a small community may be another reason for desire to move to the city.

Desire to work questioned again. Patient's work history does not indicate laziness, however.

Question of neurodermatitis is one for the physician. Specific limitations would indicate that this is probably not the primary cause of his difficulties.

Has some insight concerning his physical appearance. Discussion may also have helped him see that he has to be more careful about his personal appearance.

Good general occupational choice.

Taking civil service examination is further evidence of sincere desire to work.

Counseling Developments**Possible Implications**

for general clerk at the grade 1 and 2 levels.

Since there would be a delay in receiving a civil service appointment, the patient was also referred for clerical placement to the state employment service. Probably because of age and appearance he was not able to find placement.

Consultation with the contact section resulted in their obtaining for the patient a letter from the VA office in the patient's home state which gave him an additional ten points preference to add to an already respectable clerical test score.

The patient was placed as a government clerk and likes his job. He has been seen informally three times over a period of about one year and has now advanced to a grade 3 clerk. This work still is below his level of ability, but he is happy with it and satisfied with his salary.

The veteran reports that he did not move the family to the city because his wife wanted a divorce. This is his version and was not checked, since he had left the hospital and seemed to be making a good adjustment. He brings the oldest daughter down for visits but does not seem to miss the other children greatly. He is living with his parents again and is happy with the arrangement. He still has some difficulty with his eczema but felt that it was getting better. He has not been rehospitalized.

This brief referral to the contact section was crucial in obtaining a position later.

Test score was further indication of ability for clerical work. There was not enough time for referral to the educational therapist for trial work or bookkeeping refresher training.

In the past the patient has been content to take work somewhat below his level of ability.

No family responsibilities now.

Probably will make a good vocational adjustment. On his particular job ability is much more important than personal appearance.

Back in the protected parental environment.

Perhaps not the best overall social adjustment, but he may be able to stay out of the hospital.

ADULT PROFILE SHEET

• FOR MEN •

For Form BB of the
KUDER PREFERENCE RECORD

(Profile for Women on reverse side)

DIRECTIONS

Follow the directions below carefully:

1. Check to see whether all questions were answered. Then detach the answer pad from the test booklet by lifting the pad upward from the binding. ☐
2. Turn the answer pad over to the left page which is marked with the figure 1. Count the number of circles in which holes are punched, starting at the arrow. Do not count the cases in which there are three punches in a circle, since these punches represent errors. In the space for score 1 on the cover of the answer pad record the number of holes you have counted. ☐
3. Follow the same procedure for each of the other scores. Note that scores 2 and 3 are obtained from the same page, and that scores 6 and 7 also come from one page. ☐
4. Obtain the count again for each score, recording your answers in the spaces provided on each page, and compare these scores with those entered on the cover. In cases of differences, make the counts over again until you are sure the scores are right. ☐
5. Enter the nine scores in the space provided at the top of the chart on this page. Men should use the chart at the right; women should use the chart on the reverse side of this sheet. ☐
6. Find the number in column 1 which is the same as the score entered at the top of the column, and draw a line across the column at that point. Do this for each column. If a score is larger than any number in the column, draw the line across the top of the column; if it is smaller, draw the line across the bottom of the column. ☐
7. Fill in the entire space between the lines drawn across each column and the bottom of the chart. The result is the "profile" for this test. The examiner's manual contains suggestions for interpretation. ☐

JOB SUGGESTIONS for MAJOR INTEREST AREAS:

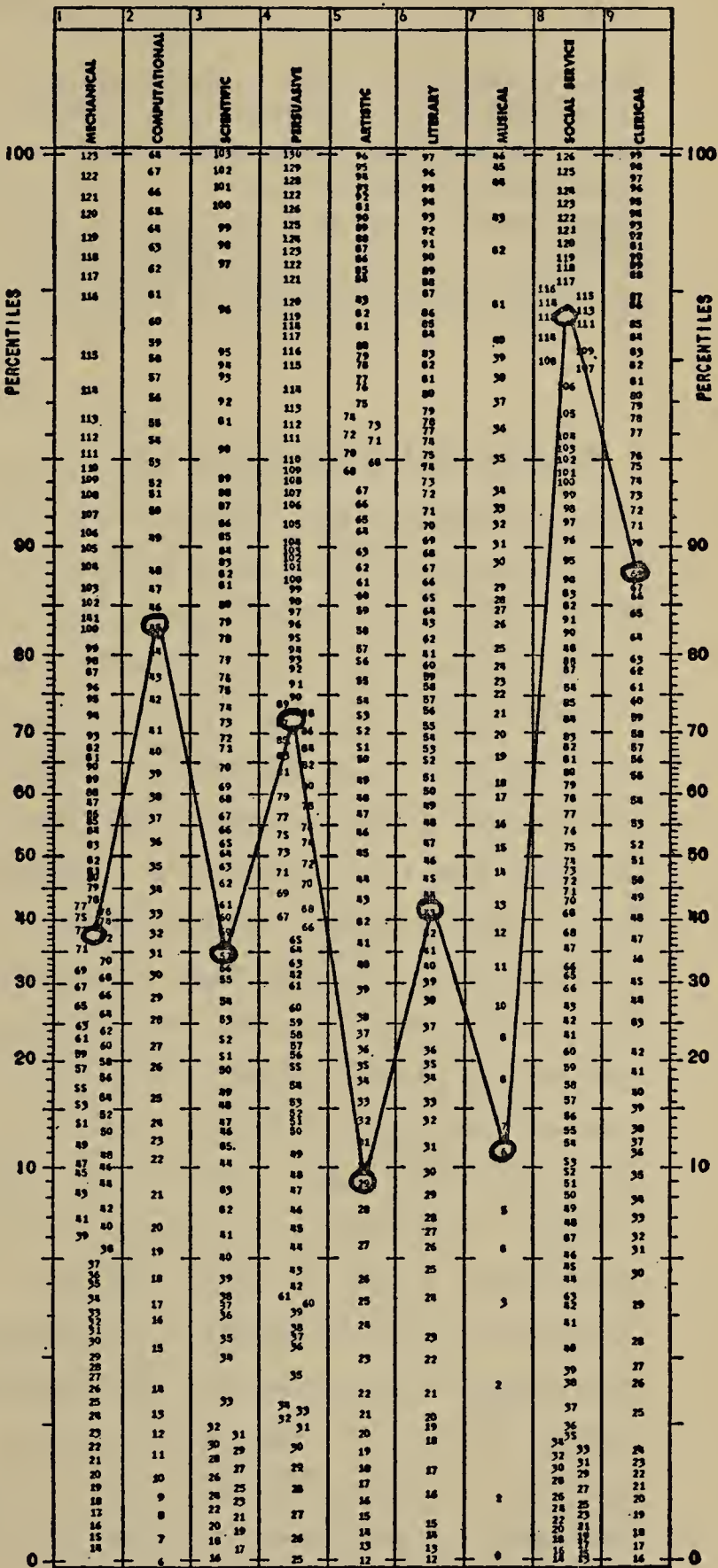
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Published by

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UT37E



Patient G Test Results

<i>Test</i>	<i>Norm Group</i>	<i>Raw Score</i>	<i>T or S Score</i>	<i>%ile</i>
AGCT (AH)	WW II army induc-			
	tees	94	115	76
Minn. Clerical Test—Nos.	Employed men	115	60	84
Minn. Clerical Test—Names	“ “	103	57	76
Minn. Clerical Test—Nos.	Male clerks	115	42	21
Minn. Clerical Test—Names	“ “	103	40	16
Minn. Paper Form Board (MA)	WW II males	44	54	66
Woody-McCall Arithmetic—9.1 grade score (RS 29)				

S U M M A R Y

Vocational counseling with skin patients is often difficult, since, among other things, there are many possible causes of the skin condition; hospitalization may be long and the results of treatment discouraging; and the patient may have been advised to avoid exposure to so many conditions and possible causative agents that placement in work or training may appear to be impossible. Some of the possible diagnoses and causes of skin conditions were reviewed to provide background for the vocational counselor in resolving questions with the physician concerning his patient's physical status. Neurodermatitis also was discussed briefly, and the counselor was cautioned to avoid considering all skin conditions to be caused by purely emotional factors. Very real skin conditions, caused by physical factors, do exist, and these call for careful job planning and placement activities in the counseling process. Counselors working in this area should consult the references cited in this chapter to learn more about such matters as skin irritants, occupations and their principal dermatological hazards, and the importance of underlying emotional factors in neurodermatitis. There is a tremendous amount of available literature on this general area, both on the specific possible irritants and on the emotional factors involved in dermatitis.

A case study was included to illustrate some of the typical problems encountered in vocational counseling with skin patients.

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PART FOUR

The Counseling Process

17

Counseling Interview Considerations

PREPARATION FOR THE INTERVIEW

Many referrals for counseling are so brief and uninformative that they serve little more purpose than to notify the counselor that a problem may exist for a particular patient. It is not at all unusual for a referral to read "for psychometrics," "this man needs a different job," or, in one extreme case, "for vocationalization." Even the carefully composed referral (from a physician more familiar with vocational counseling activities) which reads, "this patient has a particularly brittle form of diabetes and needs to change his occupation to one requiring more constant daily energy output," leaves the counselor with important preinterview spadework to be done.

The medical chart will reveal details of the admission, the kind of treatment the patient has undergone, the patient's present condition, and, of course, the projected treatment plan. The ward nurse will be able to furnish useful information about the patient's feelings, reactions, co-operativeness, and efforts to get well. From both these sources, the counselor will be able to learn what to expect in the way of the patient's physical appearance. Even the case-hardened counselor will sometimes find it difficult to mask his feelings when he unexpectedly comes upon an unusually disfigured patient. Social service reports and records of previous hospitalizations are also usually available in the file. All of these sources of information will help the counselor to familiarize himself with

the facts of the case before meeting the patient for the first time.

Some might argue (for example, 112, p. 5) that such information may prejudice the counselor's chances of working with a patient without preconceived prejudices or biases; but if one is to avoid acting optimistically or pessimistically at the wrong times, giving or denying information with the wrong patients, denying dependence or fostering anxiety by the wrong reactions, he must know all that he can in advance about his patient. These are observant, sensitive, reacting human beings with whom the counselor is working. They expect him to be familiar with the facts of their hospital history.

POINTS OF ENTRY

The initial referral for counseling may have come from a variety of sources: the social worker, a physical medicine therapist, or the clinical psychologist. In such instances, the counselor must always remember that the ward physician is to be considered the ultimate source of referral. He is responsible for the total treatment plan of the patient, and counseling is useful in the hospital if it contributes to the total treatment plan. It is well always to consult the physician about the patient before the first contact, unless the consultation sheet is particularly clear and originated with the physician. This is important primarily because it enables the counselor to find the right point of entrance into the time sequence of the total rehabilitation plan. Fletcher (60, pp. 240-243) recently provided a nice illustration of the fact that there are points of entry for the counselor into certain stages of the total treatment and adjustment process.

Although generalized plans showing where the counselor enters the picture could be set up as teaching devices, the point of entry for the counselor will vary considerably with individual disease entities and individual patients, and accurate information needs to be secured in each instance from

the ward physician before the counselor starts his series of interviews. The patient with a myocardial infarct may feel well and have expressed desire to begin counseling to the social worker or contact officer. The doctor may have agreed to the need for counseling but also may feel strongly that complete bed rest for this patient for another six weeks does not include thinking about vocational plans. On the other hand, an ulcer patient may not be responding to treatment and ordinarily would not be ready for interviewing and counseling; but the physician may wish to have the counselor start future planning with the hope of a radical change in patient attitude and motivation. A case study illustrating this last situation is given at the end of this chapter.

THE BEGINNING INTERVIEW

As Tyler (136, pp. 24, 25) points out, the beginning interview is an anxious moment for both client and counselor. Neither knows just what to expect or how he will proceed. This is apt to be especially true in the hospital situation, where the patient does not feel well to begin with and may be apprehensive of treatment processes, and where the counselor is being particularly careful to co-ordinate all his activities with those of other team workers.

The counselor, having done some research on his patient with the doctor, the nurse, and the chart, will have begun perhaps to formulate plans on how he will proceed; but it also seems desirable for him to see the patient for the first time on the ward. This allows the counselor to meet his patient with less preliminary build-up and in the ordinary framework of hospital activity. This is not to say that the counselor should engage in the gathering of personal data in the ward atmosphere and lack of privacy. He will probably wish simply to introduce himself, to describe his services in general terms, and to suggest that he will contact the patient at a later date to see whether or not there is any contribution to his plans that the counseling service might make.

The counselor may also wish to leave with the patient a brief description of the counseling service, such as the one shown in Appendix B.

Seeing the patient initially on the ward should make less anxious the patient's later arrival at (or delivery in a wheel chair to) the vocational counselor's office. And, perhaps the patient will be more likely to come to the counseling service as a result of his own motivation. It is easy to forget in the hospital situation that patients report to many services more or less on order for the execution of medical tests, and the experiences they have are not always pleasant. It is often much easier to start a conversation with a patient who has been seen on the ward who is not wondering what lies in store for him on this new service.

In discussing initial meetings with patients, brief mention should also be made of the wearing of white coats by hospital vocational counselors. The question usually comes up with new counselors, who feel that there may be some advantage in identifying the counselor more closely with the hospital setting. The counselor, however, should not wish the patient to identify him with the physician and to expect diagnoses and prognoses of his physical condition; and since the counselor does not require a protective garment, this type of clothing is unnecessary, if not undesirable. In fact, the counselor who wears a business suit may appear to be a more effective link to the outside world of occupational adjustment. Perhaps this is not so true for the clinical psychologist, who may find himself engaged in psychotherapy; but even here it would seem that the psychologist who adopts one of the traditional symbols of medicine is more likely satisfying his own needs than he is considering well-based patient relationships.

INTERVIEW ADMONITIONS

In gathering complete background information in order to fully understand the patient and his problems, the vocational counselor can easily become too rigidly tied up with the sys-

tematic completion of forms. It is easy to get into a set pattern, always starting and ending the interview in the same fashion and always using the same techniques. In hospital and other kinds of vocational counseling it is well to start the interview where the client wants to start. One can easily fill in the gaps at a later time, and perhaps more effectively, when the patient is so motivated. No counselor should act like a census taker or an investigator. To avoid this and to utilize counselor time to the best advantage, consideration should be given to personal-data sheets and problem check lists, which are completed by the patient and reviewed with him by the counselor. Samples of these are given in Appendix B.

It is also very easy for the vocational counselor to get just the answers he suggests to the patient. In order to avoid this rigidity, it pays, even the experienced counselor, to review, from time to time, some of the procedures that seem to make interviews more effective. Such review is particularly desirable for hospital counselors, since institutional settings seem to favor set routines. It is decidedly worthwhile to review the fifty-five points on interviewing given by Bingham and Moore (21, pp. 29-42). The more recent compilations by Darley (43) and Wrenn and Dugan (174, pp. 35-38) also list a number of simple but frequently neglected points. And although the admonitions cited by Wrenn (173, pp. 164-167) were prepared originally for vocational counseling interviews with students, the following adaptation is applicable to rehabilitation counseling and should be reviewed periodically.

1. There should be a definitely scheduled time and place for counseling, where there is freedom from distractions and a counseling situation is expected.

2. The interview is not the whole counseling process. Other stages in the process include such things as recording notes, gathering data about the patient from outside sources, conferring with other team members, and assisting the patient in exploring the world of work.

3. Test scores and other personal data should be presented to the

patient in such a way that the data are allowed to speak for themselves; using the third person to present such data may be helpful.

4. The interviewer should not sit in judgment of the patient. The patient should be heard as an equal.

5. When underlying feelings begin to emerge in the interview, the interviewer should avoid losing their significance by passing moral judgment on them or by turning away to a different topic. Instead, the patient should be helped, by listening, mirroring, or analyzing such feelings, to see their significance.

6. The interviewer should remember that the first problem presented by the patient is often not the significant one. It may simply represent polite conversation unrelated to more deep-seated difficulties.

7. The counselor should avoid trying to achieve too much with the patient in one interview.

8. A problem connection should not be assumed in every interview.

9. The counselor should feel that the interview situation is as much a learning situation for him as for the patient.

10. The vocational counselor should always remember that he needs other data to support conclusions based on the interview. Conclusions based on a single interview may well be unreliable.

11. The patient must be allowed time to think in the interview. He should not be pushed too much.

12. The counselor should avoid questions that can be answered by a simple yes or no. Questions calling for a description or a reaction will tend to insure better conversational flow in the interview.

13. If silences become long and have to be broken, simply ask the patient for an elaboration of the point he has been discussing.

14. In response to questions where the vocational counselor does not feel qualified to give answers, it is better to admit ignorance of the facts and to suggest means of obtaining authoritative answers than it is to talk in generalities.

15. In order to participate actively in the vocational counseling process, the patient needs to do much of the talking. The counselor should avoid excessive participation in the conversation.

16. Counseling should be realistic. Some facts that the counselor gives the patient are not happy and favorable. The "everything is fine" approach may not be at all realistic or acceptable to the patient who is aware of the existence of difficult problems.

17. Both parties in the interview situation should know that it has fixed time limits. A good way to end the interview is to have the patient summarize the area covered and the progress made. It should not degenerate into casual conversation.

Don't sacrifice everything for rapport. More important than pleasant conversation is the progress that the counselor and the patient are making in a joint learning situation. Counselor time is valuable, and so is the patient's time. Because he has plenty of it, it is a mistake to assume that the patient feels that his time is not valuable. The counselor should guide the interview but should not try to achieve his ends too quickly. The counselee understands that the counselor is interested in the story he has to tell and does not expect him to be impatient. It is important to let the patient think things through and answer questions. They should not be so phrased that the desired answers are already implied.

If another interview has been scheduled with a patient, it should not be forgotten. It is also very important to remember names. If the caseload makes this difficult, proper arrangement of the counseling office will assign this duty to the secretary. It is likely that the patient doesn't expect her to remember everyone by name. But, having shared personal information with the counselor, he feels that this person knows him very well. It might prove a rather serious blow to the counseling relationship to have the counselee suspect that he has, even momentarily, been confused with another patient.

PATIENT PARTICIPATION IN INTERVIEWS

Be professional but human in the interview. Don't stifle the patient with authority or bury him under excessive conversation. There are times in the counseling process, particularly in the initial stages, where it is necessary for the counselor to "listen creatively," as Erickson (57, p. 136) puts it; that is, listening, observing, thinking, and feeling with the patient. But the counselor will also be taking an active part in the direction of the over-all counseling process, giving leads, furnishing materials, and making observations. Vocational counseling is not an all-or-none process of direction or nondirection. It is perhaps best thought of as a non-

authoritarian process that makes use of the skills, training, and techniques of the counselor to foster active patient participation in the process of learning about himself and the realities of the world of work.

The patient does the real planning and makes the final choices with active counselor assistance. It is well to remember always that the patient has problems that are very real to him and that these may not always be identical with the more academic views of the counselor, even though these academic views may provide useful counselor approaches to be individualized to the patient. The patient is the one who must live with the solution, and his enthusiasm for implementing the final counseling product will probably be closely tied to the amount of actual effort he has expended in producing it.

The interview situation must be one of free interchange, with the development of a plan that is flexible enough to meet the needs of both counselor and counselee and realistic enough to result in a product acceptable to the demands of the society in which the patient will function. Certainly it cannot be successful if it is too rigidly bound by the restriction of counselor habits, forms, or the rigid adherence to one school or system of psychology.

LENGTH OF THE INTERVIEW

Interviews should be short enough to remain interesting to both parties. Probably a good deal more is achieved in several short interviews than in one or two exceedingly thorough sessions. Several interviews give more chance for interplay between the counselor and the patient, with the patient as well as the counselor doing thinking, planning, evaluation, and exploring between each of the meetings. This is important to realistic planning and acceptance.

The counselor should find a good way to terminate the interview when it is obvious that little more can be gained

in a given session. It is also important for him to terminate a particular interview at a point where the counselee will not have too many things to consider before the next meeting. There seems to be no set point for this. It probably depends upon a complex of factors, such as the patient's adjustment, motivation, insight, and intelligence. When the interview has been summarized and terminated the patient should be left with some interim investigation and thinking to do.

INTERVIEW NOTES

Sarbin (115, pp. 184–197) has given us a good discussion of the importance of good case notes in counseling, emphasizing accuracy, brevity, relevancy, ease of reference, and uniformity. If the counselor is to help the patient to make orderly and meaningful progress toward a vocational goal, he needs to keep continuous case notes made accurately during the counseling process. Notes are necessary in the formulation of hypotheses and plans and to note trends from interview to interview. Robinson (109, p. 159) has shown that case notes made after completion of counseling reflect more of what the counselor thinks happened than what actually transpired. A brief interview form that may serve to encourage counselors to maintain continuous case notes has been included in Appendix B.

It is very helpful to supplement notes by using recordings, if this is feasible and agreeable to the patient. Some writers (for example, 109, pp. 9, 41) give the impression that microphones should be hidden; but it would seem that Tyler's statement (136, pp. 71, 72) that recording does not usually restrict clients, since freedom of expression depends so much more on confidence in the counselor than it does on the mechanical features of the situation, makes good sense. In addition to filling the gaps in the interview data, recordings help the counselor to get the feeling tone of the interview and to evaluate his own effectiveness.

VERIFYING INTERVIEW DATA

It is important in the series of interviews to account for gaps in the experience data and to order information chronologically. Often the patient will fill in gaps if he is asked to do so. Some of the most significant interview information, which the patient may not have cared to discuss in the first interviews, will be found hidden in these blank periods. It is also very important to verify some of the information by checking with schools, employers, and other persons who have accurate records or are well acquainted with the patient. It is not realistic, however, to think that the counselor has time to check all information the patient gives him. In this regard, the counselor can obtain some comfort from the fact that Keating, Paterson, and Stone (81, pp. 6-11), working with employment service clients, found reports of work history to be very accurate. However, the counselor working in a hospital situation may, as pointed out elsewhere in this analysis, have to be more careful, since some patients, believing that physical conditions may preclude their being tried again on a job, tend to exaggerate occupational accomplishments. The counselor should consider checking the accuracy of claimed performance by using such interview aids as oral trade tests and tool lists and by comparing the patient's job descriptions with those found in the *Dictionary of Occupational Titles* (147) and other descriptive occupational literature.

UNSCHEDULED INTERVIEWS

When the patient drops in for an unscheduled interview, try to spend some time with him if possible. In many cases he will have decided to reveal to the counselor bits of more emotionally charged information and may consider this the right time to do so. It also seems desirable for the counselor to share some of the patient's hospital experiences with him in order to be regarded as a normal, reacting person rather

than an objective fact-gathering machine. The simple courtesies of everyday life are just as necessary in an institution as they are in the home, school, or church. Long, meaningless conversations, however, where the counselor satisfies his own needs by sharing some of his own similar experiences with the patient are to be avoided. Care should also be taken not to let ordinary courtesies extend to taking actions on behalf of the client which might foster the development of overdependency, or the extension of it, in the patient. Again, the counselor has to make judgments about how far he should go with the particular patient. He will find this task easier if he pays attention to the feelings and findings of other hospital team members and is aware of the total team approach, for example, of assistance, firm kindness, or strictness, and the reasons behind it.

When a patient voluntarily brings in extra data, the counselor should be alert to some of the real reasons behind the patient's action. The veteran who brings in his discharge papers to show that his discharge was honorable may have some other service experiences to discuss but hasn't yet quite found the courage to do so. The disfigured patient who brings in pictures of his family often is in the picture himself and may well want the counselor to see him as he looked before his unfortunate experience. He is probably still having a great deal of difficulty adjusting to his new status and needs some assurance, perhaps from the physician, that he will look acceptable, if different, when his defect is corrected. The patient who brings in his wife may simply be interested in having her meet the counselor or may be trying to find out if she will accept the counseling plan. He may also be letting the counselor know what he is facing in his home and marital relationships.

THE COUNSELOR'S LIMITS

It is well for the counselor to know his limits. If he cannot handle some deep emotional problem after getting hints of it,

it is probably best that he not try to uncover it fully. The psychiatrist or the clinical psychologist might do a more effective job. Counselor and patient capacities for dealing with the data that are turned up must constantly be borne in mind, and the vocational counseling psychologist may need to remind himself occasionally that his province is the area of vocational adjustment. This means working with those persons who are capable of vocational planning with his help. It is sometimes difficult not to dig deeply into emotional problems or abnormal behavior just for the sake of curiosity, even though the resulting information may be known to have little value for the rest of the counseling process. For example, if a patient with homosexual problems describes his problem and an experience, it will probably contribute little to the counseling data or the referral information for the counselor to press for details. It is well for the counselor to know his purpose, his limits, when and where to refer patients for psychotherapy, and not to be just curious.

ADDITIONS TO CONVENTIONAL INTERVIEW DATA

In addition to conventional interview data in such areas as occupational history, service history, education, family background, hobbies, and school activities, the counselor will derive much useful information from a consideration of some of the following questions about the patient:

1. Would he prefer not working at jobs where his hands will become greasy and his clothes dirty?
2. Will he be happy to wear work clothes from home, or does he prefer business attire?
3. What does he consider a reasonable wage?
4. How does he feel about carrying a lunch to work?
5. Does he seem to be looking most for economic success, social success, prestige, or relaxation in hobby and sports activities, with work as simply a necessary adjunct?

6. How does he respect his work competence?
7. If he desires to work by himself or with large groups of people, what seem to be the underlying reasons?
8. Did he arrive at his present employment or past jobs by his own design, by chance, because the family wanted him to, or because nothing else was available to him?
9. Does he prefer country or city living? How does the family feel about it? What has he done on which to base a decision?
10. Does he have an expensive family or wife? A prestige-seeking family?
11. Are there situations in his everyday life that he finds too confining or too active?
12. Is he a joiner of organizations? How actively does he really participate in the activities of organizations?
13. Does he have a car? What kind of a car does he want to have someday?
14. Does he have plans for marriage? What are his views on the subject?
15. Is he interested in current affairs and able to discuss them intelligently?
16. Does he feel that he is a member of a group that is being discriminated against? (This is not limited to minority groups; one Minnesota patient felt discriminated against because he was Swedish).
17. What are his religious affiliations, his beliefs, ambitions, and perhaps restrictions? How will these apply to his occupational choices?

The above are some sample points that it might be profitable for any counselor to develop. It is especially important for the rehabilitation and hospital counselor to develop all available data, since he is working with clients more limited and more difficult to place in jobs. Obviously, the best answers to some of these questions will seldom be obtained by using direct questions. Some of the information may be obtained easily for further discussion by using problem check lists and by including preference items in the patient-completed interview form. It may also be profitable to develop and use occupational check lists which include such items as prestige ranking of occupations by the patient, as was done by Counts (42, pp. 16-27) and Deeg and Paterson (49). Occu-

pational check lists might also include short lists of job factors, such as those used by Jurgensen (78, 79), and job-satisfaction items, such as those used by Hoppock (75).

MENTAL HYGIENE FOR THE COUNSELOR

The writer feels that it is appropriate in a chapter on interviewing to mention the importance for vocational counselors of giving serious consideration to the matter of their own mental health and to practices that will help to insure good adjustment in the complicated job of working with people with problems.

As Wyatt (175, pp. 82-87) has said, the counseling situation "contains great potential gratification, involving corresponding risks of frustration and anxiety or indulgence and delusions of omnipotence." The hospital vocational counselor is dealing directly with involved human behavior, trying to assist a patient, hoping to contribute to the team, wanting to fill the requests of the referring physician, and thinking about his responsibilities to his organization, his profession, and society. He is trying to do these things with incompletely developed tools, an eye toward research to improve them, and too large a patient load. Moreover, his efforts are affected by the restrictions of length of patient stay, the realities of the labor market, the restrictions of disabilities, and the availability of co-operating agencies. He will also usually find administrative demands upon his time, meetings to attend, literature to read, and much to be done in the way of building good interpersonal relationships within and outside his institution. In addition to all these considerations, the counselor may never be quite sure of the degree of understanding and acceptance he has with his patients. Obviously the vocational counselor in the rehabilitation setting cannot fulfill all of these responsibilities to his complete satisfaction, and it is important that he realize this and give some time to planning how he can best achieve the most desirable ends within his limitations. Each counselor should give attention to his own

mental hygiene requirements and the proper budgeting of time and energy that is implied.

Wrenn (1973, pp. 182–190), writing on this subject, has pointed out that one penalty of dealing with intricate human behavior is that the counselor is never able to feel that he is unequivocally right or that he has complete mastery of the counseling situation. Among other things, he suggests that the counselor should:

1. Enjoy the human companionship involved in his job.
2. Be able to recognize fatigue points and avoid interviews at these times.
3. Set up achievable goals for accomplishment in one day.
4. Realize that he is merely assisting his counselee in one direction and is not trying to remake his life.

The consideration of his mental hygiene status is important to the counselor, not only in terms of his own adjustment but in terms of his possible professional effectiveness. Tyler (1966, pp. 216–217) talks about counseling as requiring that we learn to face feelings about ourselves as steadily and objectively as we face feelings of others, and states that “the whole counseling venture calls for as much honesty as human beings can command.” She speaks further of the satisfactory counselor personality as one “that permits rich and deep relationships with other human beings to develop.” These things would not be likely to characterize the counselor who spreads his energies indiscriminately in many directions and, after a harried day, goes home to rationalize his feelings of lack of accomplishment by citing inadequate staffing or the inefficiencies of other services.

Some specific items for the vocational counselor to consider in maintaining his own mental health are the following:

1. Real dedication to vocational counseling and to working with ill and disabled people is essential. Surface interest will not carry the counselor far in a rehabilitation setting. If there is some question of dedication, the counselor should resolve it quickly or move to another area of psychology or to another general field of work.

2. The counselor should not try to do his job alone. He needs the help and resources of many people and other agencies to be most effective. He should also consult often with his fellow counselors.

3. The counselor should know what he is trying to achieve in his role as a vocational counselor and a team member and should do all he can in his own area of competency. Beyond this he should recognize his limits and be willing to refer.

4. If patients are referred before they are ready for counseling, the counselor must have the courage to indicate this and not spend time in an unprofitable situation.

5. Loss of time, prestige, and peace of mind will be avoided if the vocational counselor will learn that he cannot promise specific results before counseling has started or on the basis of incomplete data.

6. Counselors should change periodically to different disability areas, if this is possible, to avoid the possibilities of frustration, boredom, and becoming case hardened.

7. Since staffs are limited in size, the counselor must develop an ability to judge which cases should be given the most time.

8. The counselor must realize that he is most likely to hear about the patients whose plans do not work out and that this may not be a true picture of his effectiveness. A bit of systematic follow-up from time to time will be wholesome.

9. The counselor should keep his feet solidly on the ground, knowing that he will probably never have all the answers. But he can take comfort from the fact that other applied sciences make progress with far from perfect tools at their command.

10. The counselor who is seeking always to improve his techniques will probably have little time to become depressed over occasional failures.

ILLUSTRATIVE CASE STUDY

The following case study illustrates some of the interview considerations that have been discussed. In this case, for example, the counselor was brought into the treatment plan before medical treatment had become effective, in an attempt to motivate the patient to get well. This patient was also allowed to begin the counseling relationship where he wanted to, and a series of many short interviews were necessary to overcome his resistance. Additional interview considerations are indicated in the right-hand column.

Patient H: duodenal ulcer; age, 33; prior modal occupation, general farmer.

Counseling Developments

This patient is a thirty-three-year-old, white, male veteran of World War II. He was admitted to the hospital for treatment of a duodenal ulcer. He had been hospitalized four years previously for a heart condition, for which he has a 100 per cent service-connected disability. At the time of this counseling he was receiving an allowance of \$172.50 per month. The patient also was considered a hemiplegic, with considerable limitation in the use of his left leg and left arm. The veteran had not trained under laws administered by the VA but is eligible for consideration for rehabilitation training. He had participated once before in vocational counseling.

The patient was referred for additional vocational planning by both his ward physician and the chief surgeon. It was felt that surgery was inadvisable for this patient because of his heart condition, but his ulcer was not responding to treatment. The ward physician felt that if the ulcer condition could be controlled and improved, the patient would have to find some sort of gainful employment to keep him busy and to prevent excessive worry. The physician also felt that work requiring some use of the left arm and leg would not cause further injury but might help to regain some function in these extremities. It was also felt that the usual cautions with a heart patient of this kind would have to be considerably modified in the interest of getting the

Possible Implications

Difficult combination of disabilities. Limited in diet; cannot do heavy work or jobs requiring two hands, heavy lifting, climbing, continuous standing, extensive walking.

Does have training eligibility; some evaluation of work experiences and ability is available.

Real need for counseling felt when referral is also made by the chief surgeon.

Implication that psychological factors are interfering with the effectiveness of the usual treatment plan. The patient was not actively unco-operative.

Recognition by the physician of patient's desire to get well.

Indication that he may have more possible function in arm and leg than his actions would indicate.

Limitations imposed by disabilities are specific to the patient and must be considered in the light of other compli-

Counseling Developments

patient active, getting him to work to relieve excessive worry.

The patient was first seen on the ward. He was unresponsive and seemed almost apathetic. His responses were limited to an occasional yes or no and, more often, to infrequent nodding. He was not limited to bed rest but sat in a wheel chair, going about the hospital only when pushed by someone else. He seemed depressed and anxious and not willing (or able) to discuss his feelings. The nurses and the ward physician felt that he was co-operative about ward routine, but they were not at all sure that he wanted to get well. It is interesting that a physical capacities report completed by his ward physician during the hospitalization four years prior to the present admission indicated hemiparesis due to a cerebrovascular accident. The patient can manage his own care completely and walks well.

Records of the earlier counseling and admission data revealed that the patient is married and has two children under ten years of age. He lives in a very small community in Wisconsin. His home was built for him by his father, and it is free of payments. There is another town nearby, but it is small and offers little employment, except in family-run businesses and heavy work. Social service data indicate that the patient's family and his father's family get along well.

Possible Implications

cating factors. No general pattern for all heart or ulcer patients applies here.

Doesn't accept the counselor. Either doesn't feel the need for counseling or is too anxious to admit it.

Little drive to help himself.

Nurses see the patient most often and are a good source for likes, dislikes, general attitude, and other personality factors.

Feeling is general that patient lacks motivation to get well.

Should be able to walk now but isn't doing so. Ulcer was only additional finding during current period of hospitalization.

Close home ties. Good family relationships.

Financial stress is not a likely cause of anxiety or depression since patient receives disability compensation and has no home payments.

Has been very dependent on parents.

No employment opportunities in immediate community. This presents a problem, since it may be foolish to try to move such a physically limited person from a stable financial and social situation.

Counseling Developments

The patient is a high school graduate. Prior to service he operated a 280-acre farm, in relatively poor farming country, for about four years. Prior to this he had been a bulldozer operator for four years. He spent approximately two years in the Army as a radio repairman and had a twelve-week radar course. He does not volunteer much information about his service experience but apparently had little difficulty adjusting to service. After discharge from service he worked as a logger for two years and then as a farmer for a little over a year. The record also notes that of all his jobs he has liked farming best. He did not particularly like high school. While in high school he liked science best. He was active in extracurricular activities, playing on the basketball team for three years and playing trumpet and saxophone in the band for two years. He also participated in dramatics. After the war he seems to have had no significant hobbies. In the line of sports, he still likes to be outdoors and goes fishing whenever he can.

Test results from the first period of hospitalization indicated high-average general mental ability (Army General Classification Test score at the 67th percentile for World War II inductees). Patient also revealed very good ability to understand mechanical principles as measured by the Bennett Mechanical Comprehension Test (AA) (at the 92d percentile for a beginning apprentice-trainee norm group.) Ability to work rapidly and accurately on routine checking tasks was very low compared

Possible Implications

Steady work history—not a job-jumper. Apparently has been a hard worker.

Fair achievement in service.

All jobs have been active, outdoor ones. Quite a change to present hospital status—an understandably difficult adjustment to make.

Basketball activity may not indicate preference for sports—came from an area where boys are expected to play basketball.

Apparently not retiring or depressed in high school.

Higher level of general ability than counselor would have judged on first seeing the patient. Very good, since time limit probably handicapped him some.

Good understanding of mechanical problems. Probably influenced by Army, farm, and other work experience. Liked science in high school.

Handicapped by speed factor on clerical test. Question

Counseling Developments

to employed men (less than the 10th percentile for numbers and names on the Minnesota Clerical Test). On the Minnesota Paper Form Board Test (MA), given during the second period of hospitalization, he scored below the 3d percentile for a general population norm group. On the Kuder Preference Record (BB) highest scores in terms of percentiles were social service (92), scientific (70), and mechanical (55). Lowest scores were on clerical (3), persuasive (7), and computational (4).

The veteran's desire on discharge from his first hospitalization was to return to farming. The counselor and physician felt at that time that chicken farming might be a possibility. The county agent and the veterans' employment representative in his home county were going to try to work out a suitable plan for training or placement in the agricultural occupational area. GI Bill on-the-farm training was considered a possibility.

A farming arrangement was not worked out, however, and one month after discharge from the first hospitalization, the patient wrote to his counselor asking about the possibility of college-level training. A reply to him indicated that this was possible but suggested that he consider additional

Possible Implications

applicability with this patient. Paper Form Board Test given almost entirely as motivating device; high score was not expected, since patient would have trouble just unfolding the test. Minnesota Spatial Relations Test was not given because he was in a wheel chair at the time.

Social service score may be partly a reflection of extended hospital experience. Definite lack of experience in clerical area, which would be very suitable for his disability status.

Chicken farming not realistic in this area unless done on a larger scale than the veteran could probably handle either physically or financially. Inadequate planning, but compliance with patient's wishes made him happy at that time.

Patient was not depressed during the first counseling and perhaps could have been faced with the infeasibility of his plan.

Farming had not really been fully accepted or worked out as a good plan.

Patient might have been urged more strongly at this time to come in for additional counseling. Contact by a social worker or veterans' repre-

Counseling Developments

planning for light work by contacting the employment service officer in a larger community about fifty miles from his home. Patient did not act upon the suggestion at that time. The county agent and the employment officer were informed about the patient's letter. The patient remained unemployed for about three years. This was the extent of the information available from the earlier counseling.

With this information, the counselor saw the patient on the ward for several interviews. He was on a large ward where privacy was not possible, so counseling, in this stage, actually amounted to dropping in for casual visits. At first there was little conversation, and visits were brief. Comments about the very evident display of pictures of his children finally brought about conversations still of a limited nature but expressing great pride in them and gradually expressing concern for their future. At this point he agreed that perhaps he could come to the counseling service to talk about future plans.

On the first two or three visits he required the services of an attendant to push him down to the office. After that he came alone in his wheel chair. He would not talk freely at first, until the conversation was brought around to the subject of family and children. Counseling still consisted mainly of visiting. It was obvious that the patient was not at all at ease, since he fidgeted in his wheel chair, rubbed his left arm a good deal, and stared at the floor. He

Possible Implications

sentative should have been considered.

What appear to be nonproductive, informal visits may be necessary with an anxious patient like this to allow him to look over the counselor and decide whether or not he wishes to work with him.

Evidences of interest or pride, such as pictures, usually provide a safe area for starting early conversations. Without such evidence, family could be the worst place to start.

Some acceptance of counselor seems to be developing.

Able to do more for himself when interested in trying.

Still no real acceptance of an active role for himself in the counseling process.

Counseling Developments

was, however, keeping appointments without the demand of the doctor that he do so.

The counselor decided that since improvement of motivation to get well was essential with this patient, a program of convincing him that he could work might be worthwhile, even at the possible expense of overselling him on the idea and being unable later to produce the kind of job the patient might desire.

The following things were done:

The patient was shown how he might use his left hand, at least as a weight or guide while writing or drawing. Drafting was mentioned as a possibility. He was not active in educational or occupational therapy at this time, since he had not been interested in hospital procedures.

He was convinced by the counselor that it might be worthwhile to take a mechanical aptitude test. The results of the Minnesota Paper Form Board Test were low, but interpretation of results was confined to discussion of the fact that he was able to do something with the test items.

The patient was encouraged to bring his wife to the office the next time he visited. She showed a lot of interest in the patient's future and indicated, in his presence, probably simply because of the nature of the vocational counseling service, that she was sure he would work again and that she appreciated our efforts to help plan. She made much of his ambition before his cerebrovascular accident and seemed to

Possible Implications

Fairly dangerous. Generally a counselor would wish to be quite sure that he could produce what was promised. In this case any technique that might work had to be used because the ulcer condition was severe and considered inoperable because of general physical status.

To refresh his memory on physical things he could do.

To appeal to his mechanical interests and knowledge.

Good results were not expected because of the time element and the folding of the test.

It was known from the informal conversations that the patient highly regarded his wife's opinions and her contributions to the children. She was known to the physician as a nice person, and the counselor felt that her influence might carry more weight than the influence of any one in the hospital.

Counseling Developments

help awaken a spark of pride in the patient in his previous accomplishments on the farm. He seemed to realize that he had made some contribution to his family.

A VA regional office training officer agreed to see the patient to help encourage him. He pointed out parenthetically that men with much more disability, for example, some paraplegics, had participated in training programs and were now successfully employed. The possibility of securing training in trades courses in high schools with manual arts departments near his home community was discussed.

The patient was also included in a small group guidance meeting of disabled patients, where general questions on counseling and training laws were discussed. He did not participate much in the discussion, and whether or not he was impressed by the presence of other disabled patients who did participate is unknown. He did indicate some interest in the work of an X-ray technician at the close of this meeting.

He was also assisted in making a formal application for rehabilitation training.

After these efforts to motivate the patient to participate in counseling, he did tell the counselor that he did not really have financial worries with his home paid for, his disability allowance, and the occasional help of his parents. He indicated that he wanted to continue living where he was but was worried about what his children

Possible Implications

The training officer had been briefed on the problem and was more optimistic than usual, although special programs are set up for severely disabled veterans.

Schools were contacted in two communities within fifty miles of the veteran's home. Courses could have been made available in one of the schools.

Done in the hope that the patient might be inspired by seeing obviously disabled persons displaying active interest in planning for a productive future.

Vocational interest, realistic or not, is beginning to appear.

Family ties are very strong—probably his basic problem.

Another problem is the necessity of accepting limited activity after being accustomed to active outdoor activity.

Home woodworking the traditional thing to do. Doubt

Counseling Developments

would think about his inactivity when they become older. He felt strongly that he had to demonstrate in some way that he could still be a productive individual. He indicated interest in mechanical or medical-technician kinds of work. He also had considered doing some light woodworking in his home. There was also the possibility that he might move to a slightly larger town if he could find light employment.

The counselor indicated that arrangements would be made in his behalf to find employment when he was ready for discharge from the hospital and that training for work at home was possible if he decided on that. The patient seemed not at all discouraged at this point, but the counselor was not at all sure that he could produce what had been promised.

The patient's interest in the planning seemed to increase greatly. To maintain this the counselor dropped in for a brief visit whenever he was near the patient's ward.

About two months after this period of counseling had started, the ward physician indicated that the patient was now making medical progress. The ulcer was almost cleared up, the patient was using his left arm a little, and he was now walking (even with a little spring in his gait) to the canteen and back. The wheel chair was not being used at all. It was indicated that he would soon be ready for discharge. The physician felt that change in attitude had been an important factor in his response to the ulcer treatment program.

Possible Implications

that he really wants this—probably suggested by someone else.

Important to follow through on possible employment arrangements, even if the chances in the local industries seem poor. No time to chance losing the interest that has now been generated.

Not much for the counselor to do during this period but sustain interest and wait for developments in patient's physical status.

In this particular case, the patient's active planning for future productivity was very important to the success of his medical therapy.

An instance of counseling starting in the active treatment phase of hospitalization. Treatment and adjustment stages for this patient overlapped almost completely.

Counseling Developments

The patient was seen again with his wife. They felt that they would move to a slightly larger town, if necessary, when employment could be found. They agreed that farming was not a good choice and that chicken farming, in order to be profitable, would have to be a larger venture than they cared to try. Farming was relegated to the home-gardening level.

The patient felt that he would not want to go to a larger city to a school or hospital to get training as an X-ray or medical technician. He probably would have had trouble physically and academically. He felt that a try at employment in the local industry might be best before deciding to do light woodworking or "fix-it" work at home. He agreed that in his part of the state the making and sale of light wooden novelties to tourists might be difficult because of competition from the larger novelty firms and the Indians.

The patient was discharged from the hospital shortly after this interview.

With the co-operation of the VA regional office and through correspondence with the local office of the state employment service, a meeting was arranged in a nearby town with a VA training officer, an employment service representative, the county service officer, the personnel officer of a large manufacturing firm, and a representative of a local social service agency present. Employment and housing for the family were discussed, and the veteran was informed that the local company would try to find light work for him in the next month or so.

Possible Implications

Not really interested in moving but anxious to find work.

Farming is seen realistically without apparent depression.

Interest in technician and scientific jobs probably is not too powerful—rather easily set aside.

Seems not to want merely to be busy. Seems to require work that will be profitable as well as diversional.

Utilization of community and agency resources in the total counseling process.

The counselor needs to have good relationships outside the hospital.

Counseling Developments

Follow-up indicated that the veteran was motivated enough now to come fifty miles from his home to file a formal application with the state employment service and the company. The counselor also requested that a social service follow-up be made at the patient's home. This was done by a regional office social worker. He found the family hospitable and the veteran in good spirits and apparently holding his own physically.

As an example of how much every word may mean to a patient so anxious to prove himself, the following incident is of interest: the social worker agreed, while having coffee in the patient's home, that interest in people is certainly very essential to good performance as a social worker. He also commented on how well the patient got along with others. A few days later the social worker received a letter from the veteran indicating that as a result of their last talk, he had decided that perhaps he should look into the possibilities of becoming a social worker. Since geographical, disability, and ability factors did not make this possibility too feasible, the social worker discouraged it by letter, apparently without depressing the veteran's newly found general enthusiasm.

The veteran has been seen on two routine follow-up visits to the hospital. The ulcer condition remains cleared

Possible Implications

Good indication that there is now real motivation to work and stay well. He was not doing just what was expected of him while a patient in the hospital.

Follow-up is important to further motivate the patient, to learn about his morale, and to know what has transpired should he re-enter the hospital.

Good regional office cooperation in continuous counseling process.

Illustrates the difficulties that offhand remarks can lead to with a patient who is still grasping at straws.

Counseling is more than just casual conversation.

Good learning experience for the social worker; he happened to be fairly new on his job.

Efforts to find this patient placement did not work out as planned, but it is felt that

Counseling Developments

up after a period of about six months. The manufacturing company job did not materialize. The veteran was able to find a part-time job, doing light repair work in a small garage ten miles from his home. He was in good spirits, mentioned that he and his wife have a large garden and that he had done some repair work around the house. He is enthusiastic again about fishing and apparently divided his time about equally in the summer between fishing and part-time mechanical work. He seems to have worked out a good occupational plan for one in his physical condition. He now feels that he again has a trade. The part-time aspect is not bothersome to him, since he has no real financial problem.

Possible Implications

counseling paid off in terms of motivating him well enough to find his own employment.

Although this employment might be marginal for a less disabled person, it appears to be a good arrangement for this patient. The best thing about the present employment is probably the fact that the patient worked it out by himself.

Patient H Test Results

<i>Test</i>	<i>Norm Group</i>	<i>Raw Score</i>	<i>T or S Score</i>	<i>%ile</i>
AGCT (AH)	WW II Army induc- tees	88	111	67
Bennett Mech. Comp. (AA)	Candidates for ap- prentice tng.	49	64	92
Minn. Clerical Test—Nos.	Employed men	31	35	7
Minn. Clerical Test—Names	“ “	28	36	8
Minn. Paper Form Board (MA)	WW II males	13	28	1

ADULT PROFILE SHEET

• FOR MEN •

For Form BB of the
KUDER PREFERENCE RECORD

(Profile for Women on reverse side)

DIRECTIONS

Follow the directions below carefully:

1. Check to see whether all questions were answered. Then detach the answer pad from the test booklet by lifting the pad upward from the binding. ☐
2. Turn the answer pad over to the last page which is marked with the figure 1. Count the number of circles in which holes are punched, starting at the arrow. Do not count the cases in which there are three punches in a circle, since these punches represent errors. In the space for score 1 on the cover of the answer pad record the number of holes you have counted. ☐
3. Follow the same procedure for each of the other scores. Note that scores 2 and 3 are obtained from the same page, and that scores 6 and 7 also come from one page. ☐
4. Obtain the count again for each score, recording your answers in the spaces provided on each page, and compare these scores with those entered on the cover. In cases of differences, make the counts over again until you are sure the scores are right. ☐
5. Enter the nine scores in the space provided at the top of the chart on this page. Men should use the chart at the right; women should use the chart on the reverse side of this sheet. ☐
6. Find the number in column 1 which is the same as the score entered at the top of the column, and draw a line across the column at that point. Do this for each column. If a score is larger than any number in the column, draw the line across the top of the column; if it is smaller, draw the line across the bottom of the column. ☐
7. Fill in the entire space between the lines drawn across each column and the bottom of the chart. The result is the "profile" for this test. The examiner's manual contains suggestions for interpretation. ☐

JOB SUGGESTIONS for MAJOR INTEREST AREAS:

_____	_____
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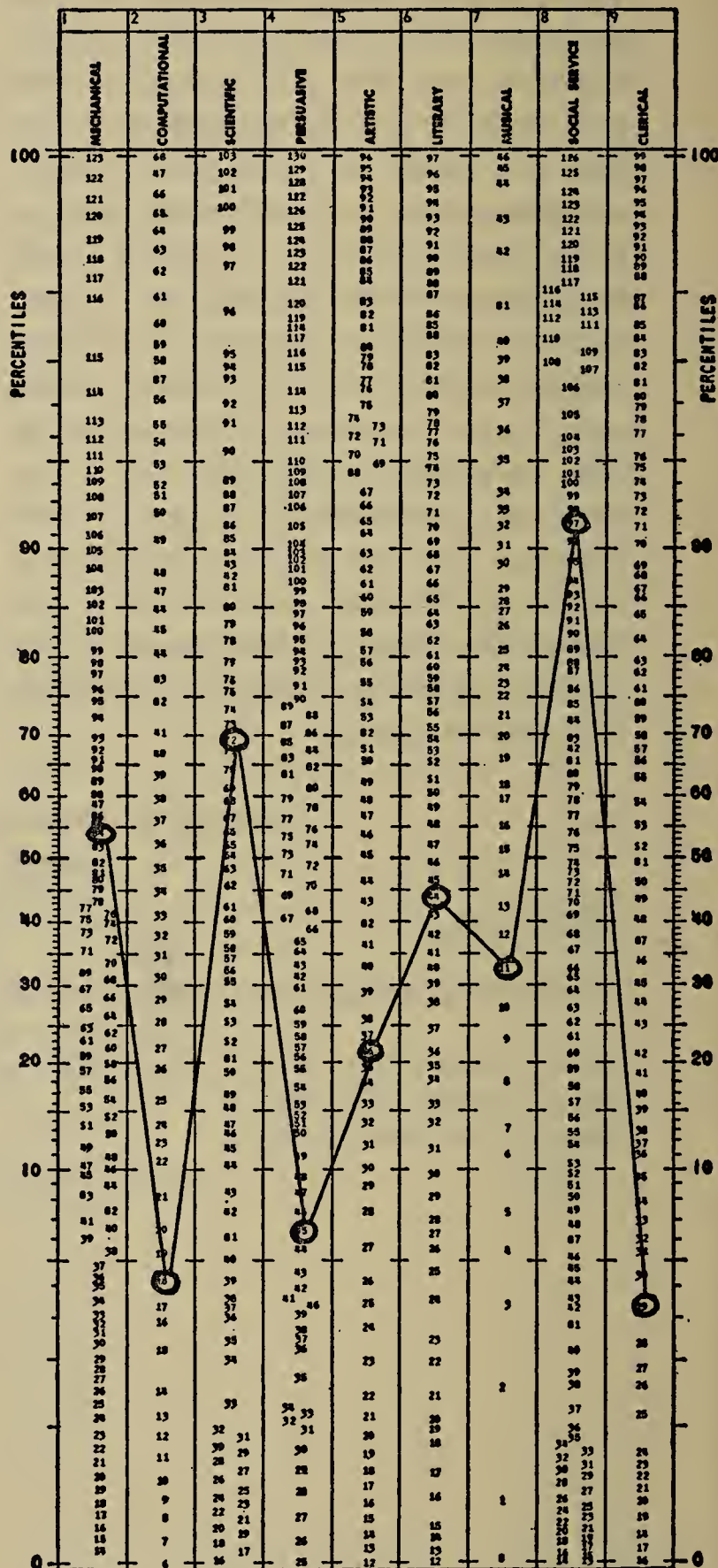
Published by

SCIENCE RESEARCH ASSOCIATES

238 E. Wabash Avenue

Chicago 4, Illinois

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SUMMARY

In this chapter good interviewing practice was discussed, with particular reference to the application of interviewing procedures in the hospital and rehabilitation situation. Special emphasis was placed on the importance of thorough preinterview preparation; careful consideration of the best point of entry with a particular patient in a disability category; using such devices as preliminary visits on the ward to assure patient acceptance of the need for counseling; avoiding the tendency to do things for patients; securing patient participation, using such devices as patient-completed data sheets and patient-selection of objectives; paying particular attention to the content of unscheduled interviews; and obtaining unusually thorough work history and personal data. A useful list of interview admonitions, adapted from the literature, was given.

It was pointed out that the "nondirective" technique will not meet the demands of interviewing in rehabilitation counseling, but that too much direction is to be avoided in working with disabled patients who are making emotional as well as occupational readjustments. A nonauthoritarian process of counseling, utilizing counselor skills and fostering active patient participation in a learning process, was advocated.

A discussion of mental hygiene for the counselor was included, since it is felt that the counselor cannot be effective in his interviewing techniques unless he himself is well adjusted to working with patients, knows his goals as a counselor, and has some idea of those things that may limit his effectiveness.

A case study was presented to illustrate points made in this chapter with regard to interviewing in the hospital situation.

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18

Testing, Diagnosis, and Theory

TESTING PROCEDURES

Testing Conditions

In the hospital setting one has to guard against fitting testing procedures to hospital routine to the extent that test results become meaningless. The best conditions that can be expected under ward circumstances are not good enough if they violate standardized instructions for the administration of the test. It is difficult to know what meaning can be attached to results of tests given on a noisy ward, tests interrupted by a penicillin shot, a time test given to a patient lying face down, or for that matter, to any patient in bed. How sincerely a patient will try to answer test questions while in uncomfortable traction or while bandaged in an unusual position is a question we cannot answer. We do know, however, that norm group comparisons are the only ones that we can make with any degree of assurance; and the norm groups certainly were tested under conditions very different from those described above. Continued testing under unfavorable conditions becomes merely a procedure to be completed in its own right rather than one designed to produce meaningful samples of behavior for consideration in vocational planning.

Testing should be done in a controlled environment, either in the counseling service itself or in a private room on the

ward. If this is not possible, the counselor should wait until desirable conditions are attainable with the particular patient.

In those few cases where immediate testing of a patient is required and good testing conditions are impossible, the counselor will do well to remember that tests are time-saving shortcuts to the sampling of patient behavior. If more time and ingenuity are expended by the counselor, he will probably be able to produce other valid data on which to base the required judgments. Certainly giving a test just to produce requested results has no meaning when conditions are such that the interpretation will yield data no more valid than those which casual observation might produce.

Test Selection

Because hospital patients are accustomed to depending upon the decisions of others and expect, in the daily routine, to have things done to and for them, it seems desirable for the counselor to make special efforts to help the patient to feel that he has a personal stake in the testing procedures. The test-selection procedures advocated by Bordin and Bixler (27, pp. 361–374), however, seem a bit too radical, even if emphasis is placed on counselor selection of specific tests and patient participation is limited to selecting areas about which he wishes information. This, it seems, would be analogous to the physician asking the patient to select the area—for example, pneumonia or valvular heart disease—on which he wishes judgments, and then deciding what tests—for example, X ray or catheterization—he will apply within that area. Incidentally, the casebook by Callis *et al.* (38) appears to emphasize counselee initiative in test selection, but, in reality, the selection is by the counselor.

The counselor must not suggest testing until he has some assurance that the patient understands the counseling process and has accepted it and the counselor. The patient cer-

tainly should be given some preliminary description of what can and cannot be expected from tests and what they are designed to measure.

There are, of course, patients for whom few tests or none at all are indicated. Too often, the counselor is viewed by the referring physician as only an administrator of tests. If the counselor has sound reasons for feeling that tests would not give valid results or would not contribute the desired data, he should so inform the physician and should, if possible, proceed to furnish the data by some other means. The chances are good that he will gain much in respect and lose little in referrals if he operates on the principle that he is better qualified in the area of psychological testing than the other hospital team members. He must, of course, be really competent in his field, be able to back up his decisions with facts, and be able tactfully to persuade his colleagues that "testing" is not all there is to the process of vocational counseling.

Tyler's reminders (136, p. 108) that old tests are better than new ones (since more data are available for use in interpretation) and that, in choosing tests, one should consider non-test information already available are worth the careful consideration of all hospital counselors. Tests must not become simply accoutrements that give counseling procedure face validity and a false "scientific" aura. They must be carefully prescribed on an individual and selective basis to yield needed specific data. There is no particular virtue in the use of many tests. Wise use of selected tests to provide specific data to fill gaps in knowledge or to corroborate or deny the implications of other data should be the rule.

If the procedures leading up to and including test selection have been effectively handled, counselors should not be apologetic or overly concerned about how tests look to the patient. Tyler (136, p. 111) has made the point that face validity is probably not important if a well-based counseling

relationship, with underlying acceptance and understanding, has been developed.

Reading Levels of Tests

The lower social, economic, and educational levels of many patients may make it desirable to establish the patient's reading level before too much is done about test selection and before test results can be interpreted with confidence. The counselor must know something about the reading levels of the various tests he is using. Johnson and Bond (77) and Bond (25) review the reading attainments and needs of students and adults and, after estimating reading levels of various tests in common use, point out that among other things, reading levels are important in test selection, administration, and interpretation. Counselors cannot assume that if the patient understands the directions for a test, he will necessarily comprehend the test items. It is pointed out that from the standpoint of reading level, the Bell, the Minnesota Multiphasic Personality Inventory, and the Army General Classification Test appear to be adapted to the general population. In addition to knowing the reading level of the tests available, it is necessary, of course, to make some estimate of the reading level of the individual patient. Some suggested clues to this include vocabulary level, as revealed in the interview; facility in interpreting questionnaire material; results of a test of mental ability, if available; and testing room clues, such as articulation, pointing while reading, frequent regressions, and excessive fixations per line. Betts (19) states that if a student at the elementary or secondary grade levels misunderstands more than one word in twenty, he may lose the meaning of a passage. Bond and Johnson suggest that this type of check may prove efficient in a testing situation.

Sequence of Test Administration

The following sequence of test administration, suggested by Super (130, p. 78), is probably a wise one to observe:

1. A warm-up or buffer test.
2. Long, difficult tests requiring concentration.
3. Tests not to be remembered in detail, and those with touchy items [such as the Minnesota Multiphasic Personality Inventory].
4. Relatively short and pleasant tests.

Effort should be made to avoid ending with tests not to be remembered in detail. This is important in the hospital situation, where patient communication is especially good and topics of conversation are relatively limited. It seems particularly advisable to give tests that include touchy items later in the sequence, as recommended, when the patient has become accustomed to testing and there has been more time to cement the counseling relationship. It may well be that patients, with their illnesses and hospital-imposed frustrations, may be more sensitive to touchy-item tests than other counselees. It is easy to violate the principle of placing these tests later in the sequence because of their general interest and because, in many services, they are sent out for machine scoring and require a day or two before results are available. Rushing to complete testing or to determine results, however, hardly seems a good reason for possibly jeopardizing the whole counseling relationship or lessening the motivation of the patient.

Administering Tests to Patients

All counselors should be compulsive about using standardized test directions, timing accurately, and scoring accurately. An Army General Classification Test returned from the testing room with the notation, "allowance should be made for five minutes of extra time" is worthless. Super (130, p. 80) reminds us that "if the test is suitable with different directions, the norm may no longer be applicable." It is also well to remember his comment (130, p. 85) that "if an accurate instrument is worth using, it is worth insuring its accurate use."

In the testing room facilities should be arranged to make

it possible for wheel-chair patients to work comfortably at a table or on a wheel-chair board wide enough to accommodate the testing materials.

Patients who report that they feel rather ill probably won't produce valid results, and, in most cases, they should be returned to the ward without taking the tests that had been planned.

When testing patients as a group, effort should be made to avoid the presence of a patient whose startling physical appearance, strong odor of medication, or constant wheezing and coughing may have a distracting effect. Such patients can easily be tested in a spare office and are likely to feel that they are receiving individual attention. The counselor should remember that he has probably become hardened to sights that may still be quite disagreeable to new patients.

Patients with visual or upper-extremity disabilities, or those who cannot sit comfortably, probably will not be able to give a good account of themselves on timed tests. Poliomyelitis patients with upper-extremity involvement, some arthritics, and multiple sclerosis patients are particularly difficult to work with in psychometrics. Test selection will have to be careful, and sometimes testing will have to be deferred for a long period. Past work achievements and academic and counseling records from school and college may have to furnish the immediately available data. These data should be secured by the counselor, even when the patient can be tested, so that valuable comparisons can be made.

In hospitals, and particularly on chronic disease services, the safeguarding of test materials is of the utmost significance. Patients do talk over tests, and leaving a test in the hands of one patient may well invalidate results from other patients on the same ward for periods as long as a year. Curiously, caution and the observation of rules in testing procedure sometimes stop with timed tests; untimed tests are left on the ward for completion, since "they won't penalize the bed

patient." More thought needs to be given to how the results on future patients may be affected by this practice.

Testing for Research Purposes

Use of a standard battery of tests for all patients may indicate serious lack of attention to the individuality of patients and the particular counseling problem. It is true that standard batteries will be used at times for research purposes. When this is the case, careful planning must be done to allow a sufficient variety of tests in the battery to meet individual counseling needs, if counseling is not to become a mere by-product of research activity. Research is necessary to progress in counseling theory and practice, but it is likely to lose its support unless the service function of the agency is also effectively satisfied. Pepinsky's treatment (105, pp. 3-15) of the reconciliation of the practitioner and scientist roles of the counselor presents all of us with a real challenge.

When a test of unknown validity is used for research purposes, the counseling staff needs constant reminding that the test does not acquire validity simply by use or because it seems to bear out hunches in isolated instances. Also, scores of tests being validated or used solely for research should not be included in reports of patients' test scores or in consultation summaries. Other workers are likely to draw unwarranted conclusions; and, sometimes, other team members will come to lean heavily on certain unvalidated tests and, by request, will tend to fix them in the battery that is used in the counseling service, even though no one really knows the significance of the results.

The Use of Trade Tests

Oral trade tests are particularly useful in the hospital situation. Patients often seem to find it easy to exaggerate the level of work that they performed. The semiskilled machine operator often will claim to have been a machinist; the

service-station attendant, an auto mechanic; and the bulldozer operator, an operating engineer. Possibly this is easy for the patient to fall into because present physical status makes it obvious that return to previous employment is not possible and there is no threat of having actually to prove job performance in the future. The patient may also be seeking prestige in a very leveling sort of environment, or he may be trying to present himself in the best possible light to a counselor who he hopes will be able to help him plan the best possible productive future.

Caution should be exercised in interpreting trade test scores that are unfavorable to a patient who is suspected of exaggerating. Patients have been known to lose interest in the counseling process when they learned directly and too suddenly that the counselor was aware of their deception. Patients who do exaggerate should not be written off as uncooperative. Rather, thought should be given to the need for prestige as possibly one of the basic problem areas giving the patient difficulty.

Oral trade tests are also useful as tools to help rebuild confidence and morale in patients who have become self-depreciative despite obvious competence established by their employment record.

Patient Behavior During Testing

Notes on patient behavior during testing may be extremely useful in the evaluation of test results and the total assessment of the patient. Bingham's suggestions (20, pp. 227-237) are helpful in this regard. He emphasizes the value of observing, as well as measuring, a person's behavior, and he urges notation of inferences from observations of test-room behavior and recording of the facts on which these interpretations are based. He gives a seven-page sample examiner's check list (with possible interpretations of behavior) which counselors might find it helpful to review from time to time. It also seems desirable to have a second person act as psychometrist,

when possible, so that patient reactions may be noted and judged independently. Where local personnel ceilings and budgets do not permit the luxury of a staff psychometrist, the same procedure can be achieved by rotating the testing-room duties among the counselors and trainees on a scheduled basis. This also allows counselors to maintain firsthand familiarity with tests.

Effects of Illness on Test Results

Available evidence (5, pp. 389–402) indicates that temporary or minor illnesses do not influence test results significantly. Presumably, then, the tests administered when the patient has recovered enough to work on the counseling service should give good results. The effect of serious and chronic illness, however, is a matter on which we do not yet have sufficient data. It would seem wise to avoid giving tests during acute illness, periods of physical stress, and critical treatment periods. It is both an important and easy matter for the counselor, when asking for a patient, to check with the ward nurse to make sure that his candidate for testing has not just completed an uncomfortable procedure, such as a cystoscopic examination or a bronchoscopy. It is equally important to know, for example, whether he is scheduled for surgery in the morning and is depressed at the prospect. The hospital vocational counselor has to be alert to many factors that may adversely affect motivation and performance during testing.

The counselor should consider the possibility that the rapport he has with the patient in testing and interview situations may not be as genuine and free as it appears to be. Patients sometimes approach the testing-room situation with a kind of resigned attitude. Because they are accustomed to taking many medical tests during their hospital stay, they are apt to feel obliged to be somewhat co-operative. Such apathetic co-operation probably can be avoided if acceptance and understanding of the counseling process are estab-

lished before tests are introduced. The counselor should also consider the possibility of a general level of depression on interest tests with patients who are hospitalized for very long and severe illnesses.

The hospital patient who feels uncomfortable physically and also thinks that his treatment should be coming along faster is likely to be suspicious about personality testing and needs careful handling. The possibility of elevated scores on personality tests for particular disability groups and particular periods of treatment should be considered. In this connection the study by Wiener (163) on the relation of personality characteristics to selected disabilities merits attention. Designed primarily to test whether personality characteristics are differentially associated with various disabilities, it utilized the Minnesota Multiphasic Personality Inventory, selected literature chiefly from the field of psychosomatic medicine, and rankings by psychiatrists of diagnostic categories according to their psychosomatic component. Eight disability groups were studied. Only two of these groups, heart disease and skin conditions, overlap the areas covered in the present analysis, since Wiener's groups were selected for different reasons. Differences were found between the groups studied, and comparisons of statements in the literature with personality test profiles were made. For example, hysterical tendencies described in the literature for valvular heart patients were supported by elevation of hysteria in the profile. It is the author's feeling that vocational counselors will be better equipped to work with patients in testing and interviewing situations if they are familiar with the data and implications discussed in this study.

Interpreting Test Results for Patients

In evaluating test results with the patient, nontechnical language is essential. The use of test profiles is helpful in staff discussions but may be confusing to the patient and lead to unwarranted discussion of norms, standard scores,

and percentiles. It may also leave the impression that tests have more validity than is sometimes the case. One wonders if the counselor needs this kind of a crutch to give down-to-earth test evaluations to the counselee. Consideration should be given to the recommendations of the Bixlers (22, pp. 145-155), which include such points as speaking in the third person; giving simple statistical predictions based on the test data; allowing the patient to evaluate the prediction as it applies to himself; remaining neutral toward test data and patient reactions; facilitating self-evaluations; and avoiding persuasive methods.

Evaluating the Testing Program

A periodic evaluation of the testing program of the vocational counseling service is revealing and useful as an aid in maintaining adequate counseling procedures. A tabulation of the number of tests used over a period of months in the hospital counseling service will give indications of whether or not the needs of the patients are being met; whether or not there is stereotypy of test selection by the counselors; whether certain counselors have fixated on a few tests; whether the best tests are being used; whether instruments like trade tests are being neglected; and whether or not the trend seems to indicate too few or too many tests per patient. Although a general survey of testing in the unit will not give reasons why certain tests were selected for individual patients, it will show trends that may provide clues to the kind of counseling service being offered to patients. It should yield valuable material for staff discussions and for training new counselors, and might be assigned as a training project.¹ A sample tabulation of the tests used by the vocational counseling service of the Minneapolis Veterans' Administration Hospital over a one-year period is shown below in tables 4, 5, and 6.

¹ Similar projects for trainee participation in the hospital phase of training are described in Appendix C.

Table 4
Tabulation of Tests Used
(April 1, 1954–March 31, 1955)

<i>Tests</i>	<i>Number</i>	<i>Per cent</i>
<i>General Ability:</i>		
AGCT	205	49.2
Progressive Matrices	154	36.9
Ohio State University Psychol.	39	9.3
Wechsler-Bellevue	12	2.9
ACE	2	0.5
Shipley-Hartford	4	1.0
Kent EGY	1	0.2
Total	417	100.0
<i>Aptitude:</i>		
Bennett Mech. Comp.	169	32.6
Minn. Paper Form Board	177	34.2
Minn. Clerical Test	114	22.0
O'Connor Dexterity	24	4.6
Purdue Pegboard	11	2.1
Minn. Spatial Relations	10	2.0
Meier-Seashore Art Judgment	5	1.0
Lewerenz Art Test	3	0.6
Engin. and Phys. Sci. Aptitude	3	0.6
Ferson-Stoddard Law	2	0.3
Total	518	100.0
<i>Interest:</i>		
Kuder Preference Record	184	55.1
Strong Vocational Interest	148	44.3
Allport-Vernon	2	0.6
Total	334	100.0
<i>Personality:</i>		
Minnesota Multiphasic Personality Inventory	212	68.2
Guilford-Zimmerman	99	31.8
Total	311	100.0
<i>Achievement:</i>		
High School GED's	46	52.8
Woody-McCall Arithmetic	17	19.5
Oral Trade Tests	21	24.1
Gray Oral Reading	1	1.2
Gates Reading	1	1.2
Co-operative Tests	1	1.2
Total	87	100.0

Table 5
Tests Administered, by General Areas of Behavior
(April 1, 1954–March 31, 1955)

<i>Behavior area</i>	<i>Number</i>	<i>Per cent</i>
General Ability	417	25.0
Aptitude	518	31.0
Interest	334	20.2
Personality	311	18.6
Achievement	87	5.2
Total	1667	100.0

Table 6
Patients Tested and Number of Tests Administered
(April 1, 1954–March 31, 1955)

	<i>One Year</i>
Number of Patients Tested	466
Total Number of Tests Administered	1667
Average Number of Tests Per Patient	3.58

From the data in these tables, it would appear that some of the following observations might be made:

1. Testing was not limited to one area, such as personality, or to general ability; and the variety of tests used would seem to indicate that there was emphasis on vocational planning.

2. Relatively little individual testing was done in the area of general ability, and this, perhaps, should be discussed with the staff.

3. Interest testing favors the Kuder over the Strong; and although this may be a result of the reading level of patients, it might be worth discussion with the staff.

4. It might be worthwhile to discuss again with the staff the usefulness of trade testing and achievement testing.

5. Frequent use of the Revised Minnesota Paper Form Board Test, and relatively little use of the Minnesota Spatial Relations Test, might be a topic for staff discussion.

There are, of course, other observations that can be made, including the fact that a fairly wide range of tests seems to have been used but that the number of tests per patient seems to have been rather small (which may be the result of previous testing done in other centers). These few observa-

tions should serve, however, to point out the possible usefulness of such tabulations.

It is also worthwhile to compare the kinds of tests used in a particular counseling service with reports of tests used in other agencies and services to get clues to the comprehensiveness of vocational counseling programs.

The data in Table 7 are taken from an article on the activities of veterans' guidance centers by Darley and Marquis (44, pp. 109-116).

Table 7
Incidence of Use of Various Tests in Testing of Veterans

	<i>Per cent Index</i>
<i>General Ability</i>	
The Otis Series	73
Bellevue-Wechsler	69
American Council Psychological	67
Ohio State Psychological	37
<i>Educational Achievement</i>	
The Co-operative Test Service Series	59
United States Armed Forces Institute Tests	38
Iowa Placement and Achievement Tests	27
Stanford Achievement Tests	24
<i>Vocational Interest</i>	
Kuder Preference Record	94
Strong Vocational Interest Blank	67
<i>Personality</i>	
Minnesota Multiphasic Personality Inventory	55
Bell Adjustment Inventory	35
Bernreuter Personality Inventory	29
<i>Special Aptitude</i>	
Minnesota Vocational Test for Clerical Workers	61
Bennett Mechanical Comprehension Test	53
Revised Minnesota Paper Form Board	43
Minn. Spatial Relations Test	37
Detroit Mech. Apt. (Mac-Quarrie)	27
O'Connor Finger-Tweezer Dexterity Test	43
Purdue Pegboard	39
Minn. Rate of Manipulation Tests	29
Meier-Seashore Art Judgment Test	22

Using a base figure of fifty-one clinics reporting in the survey as the denominator, Darley and Marquis indexed the most frequently mentioned tests by the percentage of times mentioned. Centers had been asked to give the names of tests that had proved most valuable in the various areas of behavior. Fourteen of the twenty-two tests listed as most valuable in Table 7 are listed in the tabulation given in Table 4, indicating, perhaps, that the counseling service of the Minneapolis Veterans' Administration Hospital is doing somewhat the same kind of testing with patients that the university and college guidance centers surveyed by Darley and Marquis were doing with veterans. This kind of comparison would also seem to bear on the discussion in Chapter 4 of the different orientations and testing goals of clinical and counseling psychologists.

The author, attempting to compare the testing program of the Minneapolis Veterans' Administration Hospital with that of a large psychiatric hospital, which has a large but probably more clinically oriented counseling service staff, received a letter describing the testing program used in the latter institution. This letter indicated a testing program quite different from those referred to in tables 4 and 7. It may be summarized as follows:

1. A minimum of testing is done; less than if the hospital were working with trainees.
2. Since this is a neuropsychiatric hospital, patients' histories have already been worked up by clinical psychology.
3. Supplemental testing is primarily in the personality and intelligence areas; little need is found for additional testing.
4. A better job can be done with work tryouts in hospital industry, physical medicine and rehabilitation, and industrial therapy than with conventional testing.
5. Expert observations of therapists and counselors substitute for testing.
6. Patients are long term, and counselors are not pressed for decisions as much as in a general hospital.
7. A large portion of testing is devoted to such tests as the Thematic

Apperception Test, the Minnesota Multiphasic Personality Inventory, and the Rorschach.

8. If the staff were more adequate, more testing would be done; other activities save time.

9. With less experienced psychologists more testing of the formally normed sort would be done.

Another letter, written to a hospital vocational counselor by an adviser in a state teachers college in order to supply additional information on a patient, provides a further example of differences in orientation to testing among persons engaged in vocational planning. In this letter the individual, who had served as the patient's adviser for several months, stated that he had given the patient the Rorschach and Thematic Apperception tests to help determine the nature of the patient's emotional crisis. He said that the patient was having a problem but was handling it within normal limits. Little else could be said because the scoring had been informal. This adviser, however, had suggested that the patient return to teaching and that he consider work with exceptional children.

DIAGNOSIS

The Need for Diagnosis

It would seem reasonable to conclude that diagnosis, at least broadly speaking, is an accepted component of hospital vocational counseling, since the counselor's reason for existence centers around the vocational adjustment problems of individuals who are limited by injuries or disease entities. Hospital counselors, however, will attest to the fact that this is not always so, and the literature indicates that diagnosis in counseling is a controversial issue. Nevertheless, the fact remains that in order to approach the almost endless variety of sociological and psychological problems involved in the vocational rehabilitation of the physically handicapped, the counselor will have to use diagnosis, whether or not he calls it by that name. He will have to decide what

categories of diagnosis are useful, and how such categories may contribute to the desired vocational adjustment of the patient outside the hospital.

Since Viteles (156, pp. 131–138) first wrote specifically about the clinical or case method in counseling in 1925, some kind of diagnosis has been assumed to be an important part of the process. Williamson (165) recognized diagnosis as an important part of counseling in his series of the six phases of counseling: analysis, synthesis, diagnosis, prognosis, counseling or treatment, and follow-up. Brayfield (30) devotes a large portion of his book to diagnosis. On the other hand, Rogers (111, pp. 155–159) and his followers in the self-theory school of thought stressed the needlessness and even the hazards of diagnosis. From 1942 through the 1948–1949 period, as Berdie (16, pp. 255–266) has pointed out, the need for diagnosis in counseling was a major subject for discussion. By 1950, Stuit (127, pp. 305–316), in reviewing the literature, had expressed the feeling that it is no longer a question of whether diagnosis shall be used in counseling but a question of what techniques shall be used, when they shall be applied, and how they shall be interpreted. Reviewing the literature in 1952, Gilbert (66, pp. 351–380) indicated a lack of research in the area of relating diagnosis to counseling but also pointed out that practically all books in the period, with the exception of those by Rogerians, emphasize the importance of a general diagnosis and the imparting of diagnostic facts. It should be mentioned, however, that Snygg and Combs (122), representing a school of thought (phenomenological psychology of the individual) which is much less influential than the Rogerian school, advanced the idea that diagnostic techniques retard rather than facilitate the process of self-understanding. But the majority of writers have accepted as important the idea of diagnostic techniques. And Wrenn (173, p. 149) has pointed out that even the “non-directive” counselor uses process diagnosis in his counseling in order to know how to respond while using his basically

reflective technique. The hospital vocational counselor, then, from experience, training, and analysis of the major thinking in the field will be concerned with making effective use of diagnosis.

The Development of Diagnostic Categories

Some review of the development of diagnostic categories may be in order. Recognizing the need for planning around basic categories, Williamson (166, pp. 214–217) formulated his five diagnostic categories: personal-emotional, educational, vocational, financial, and health. These are fundamentally problem areas. Using essentially these same categories, Darley and Williams (45, pp. 97–101) showed that student counseling problems could be so categorized. Super (130, p. 5) criticized Williamson's rational imparting of diagnostic data to the counselee; nevertheless, he felt that diagnosis, used properly and at the right time, was important for the counseling process.

The opposition of Rogers and his students has, as Stuit (127, p. 305) pointed out, really served to place diagnosis in a better perspective and has stimulated more serious study of the role of diagnosis in the counseling process. Perhaps the most important contribution to recent thought on the subject came with Bordin's dissatisfaction (26, pp. 169–184) with the problem-area approach involved in Williamson's categories. He proposed the following psychologically based diagnostic constructs: dependence, lack of information, self-conflict, choice-anxiety, and no information. Pepinsky (104), thinking along the same general lines as Bordin, further modified the Bordin diagnostic constructs to include lack of assurance, lack of information, lack of skill, dependence, self-conflict, and choice-anxiety. Further, he defined subcategories of self-conflict, and, most important, he put the categories to test with actual counseling cases and found that dependence, cultural self-conflict, and choice-anxiety appeared to be the least useful of all the categories. Robinson

(109, pp. 168–173) discusses classification in terms of three major problem groupings: adjustment problems, skill problems, and maturity problems.

Significance of Diagnostic Categories

What significance have these developments for the hospital vocational counselor? First, he needs a framework around which he can build plans for effective work with his patient. Useful categories have been suggested. They need further testing, and perhaps additions or modifications, that will make them even more useful. These classifications help to give purpose to data gathering, feelings, clues, and ways of combining general impressions. They enable the counselor to make tentative hypotheses which, in turn, help him to build the theories that he wishes to test with his individual patient.

The use of such constructs helps to bridge gaps in the data. This should aid the hospital worker who sometimes has to worry especially about economy of time and will welcome procedures that point to the more fruitful sources for further investigation.

Better understanding of the patient's problems should be facilitated by the use of realistic and independent diagnostic constructs. The process of using such constructs also focuses attention on clear counselor thinking and leads away from the form-bound thinking of the counselor who never quite leaves the data-gathering stage of counseling.

The use of diagnostic constructs should help the vocational counselor to make more effective requests for additional information from other services, such as social service and clinical psychology. Their use would also appear to be essential in deciding whether or not the counselor feels equipped to handle the problems presented or should refer the patient to the psychiatric service, or even to a contact officer who is better equipped to offer certain types of information if no real vocational problem exists.

In making use of such procedures as environmental manip-

ulation, the influence of family, friends, or respected authorities in the community, or group influences, the counselor would be treading on thin ice unless he bases such procedures on carefully worked out diagnosis.

It is hardly likely that the hospital vocational counselor can function effectively without diagnosis as a keystone in his procedures. He may find a need for new categories—certainly he needs to begin work on validation of existing ones. In his work he will perhaps be best guided by Bordin's specifications (26, pp. 169–184) for diagnostic constructs and will perhaps want to review the original article. Briefly, Bordin feels that, to be useful, such constructs should help the counselor to understand the situation better, should vary independently, and should point the way to the selection of a treatment or counseling plan.

THEORY

The Need for a Broad Approach

The importance of theory for effective counseling and for the development of counseling research has been nicely emphasized by the Pepinskys (105, pp. 16–21). The terms *eclectic* and *empirical* apparently have fallen into disrepute in counseling and have come to mean, to many, an approach that carries a connotation of disorderliness in thinking, weakness, and inability to fathom particular current theories of counseling. Yet the writer would hazard a guess that many service counselors in hospital and rehabilitation settings have found it necessary to take from the techniques of many theorists those procedures and lines of reasoning that apply most meaningfully to the patient problems at hand. Rigid adherence to the client-centered approach of Rogers (110), better referred to as self-theory by Pepinsky (105, pp. 31–37), leaves out a group of people who need other approaches, as Robinson (108, pp. 368–371) has pointed out. It further leaves out the kind of diagnosis essential to hospital coun-

seling; and it requires unrealistic amounts of time, with limited results in terms of the end product of successful job placement.

On the other hand, more rigid adherence to an actuarial approach, such as Sarbin (114, pp. 83–96) suggests, logical as it may seem to be, seems, as Meehl (96, pp. 207, 208) has said, to leave out something in clinical (or counseling) casework. The theoretical framework of the neobehavioral approach (105, pp. 44–60), the psychoanalytical approach (105, pp. 38–44), the communications approach (105, pp. 26–29), and so forth, all contribute to the counselor's store of ideas and techniques. But, in short, no one theory appears to embrace and satisfy the variety of counseling needs that must be faced by the rehabilitation counselor. A stimulating discussion of clinical and actuarial methods is contained in Meehl's book (95).

Building Theory as Counseling Progresses

Perhaps, as Pepinsky (103, pp. 264–268) suggests, we need to build our theory as we go, formulating and testing hypotheses in current counseling situations and gradually building a body of knowledge to support or refute our formulations. It would appear that a good many counselors actually do this, and that more are eclectic and empirical than care to admit it. Fiedler's (58, 59) finding for clinical psychologists that there is more similarity, in relationships created, between experienced counselors of different theoretical leanings than between experienced and inexperienced counselors of the same theory group may hint strongly in this direction.

Recent investigation by McArthur (93, pp. 203–207) into the behavior of experts in their approach in formulating ideas about counselees supports the notion that theories are built inductively as the case history develops; cases were not approached with a prior general theory as the framework.

These notes on theory should not be interpreted to mean that theory is unimportant. The counselor should have a

good background in both counseling and learning theory if he is to keep abreast of current developments in his field of work. But he will perhaps most realistically approach his daily caseload if he is unafraid of, and is frank about, operating in an eclectic and empirical manner. He needs to have theory, but he modifies and builds as he works with the patient and, in this way, develops a meaningful framework around which to help the patient build tentative solutions and plans and within which to carry on local research in counseling techniques.

SUMMARY

This chapter opened with a discussion of good testing practices as they can be adapted to hospital vocational counseling. Poor practices to be particularly avoided in hospital settings also were discussed. Examples are such practices as allowing hospital routine to dictate testing procedures to the point where results are meaningless; neglecting patient and test reading levels when many patients come from the lower social, economic, and educational levels; and neglecting trade tests in the hospital situation where they can be particularly useful. Sections on diagnosis and theory, as they apply to work with the disabled, were included, and it is hoped that the material they contain will stimulate further thought and research.

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² See also, references in the text of this chapter and in Chapter 19, in the section on the test reference file.

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PART FIVE

Reference Resources

19

Reference Resources and Their Use

In hospital vocational counseling in the Veterans' Administration, there has been a definite and most refreshing effort to avoid forms, set procedures, and special files. The only forms required are consultation and clinical-record forms, which are essentially blank pieces of paper on which the counselor makes his recommendations and notes the progress being made in vocational planning. This avoidance of prescribed procedures recognizes the need to encourage local individuality.

In order to gather necessary evaluation data the counselor will probably also employ such devices as patient-completed interview forms, problem check lists, and occupational check lists. In addition, he will need certain basic reference sources. Some of these will be described briefly, since it is felt that they are very important to successful work with disabled patients.

The use of forms, files, and reports that limit the counselor to the performance of administrative duties and restrict his actual participation, originality, and enterprise in vocational counseling procedures clearly should be discouraged. However, certain knowledge of occupational information, test usage, and disability information cannot be left to individual initiative. If good reference sources are available in the counseling service, there is every likelihood that the importance of these materials will be realized and that use will be made of them.

THE OCCUPATIONAL REFERENCE FILE

Most writers in the field of vocational counseling agree on the importance of adequate occupational information for both counselor and counselee. In recent years, however, attention has been focused on the more clinical approaches, learning theory, the direction versus nondirection controversy, and the growth of the general counseling movement, and there has been perhaps less emphasis on the necessity of making use of occupational information in the counseling process. Some vocational counseling units have outdated occupational reference files, little-used files, or no files worthy of the name. It would seem, then, that greater thought and effort should be devoted to the development of an adequate occupational reference file and the instruction of vocational counselors and trainees in its use. Tyler (136, p. 170) gives a timely warning when she says:

What we must be careful of, as we move on to fresh emphases, is not to lose sight of the significance of those that preceded them. The whole problem of wise vocational choice is undoubtedly far more complicated than the pioneer guidance workers thought it was, but the client still needs to be given the relevant information about fields of work in a form that enables him to assimilate it.

Paterson *et al.* (101, p. 271) stress that the counselor in his approach to vocational problems should acquire a maximum of information regarding the world of work, especially detailed knowledge of source materials. Shartle (119, p. 16) tells us that "the counselor's appraisal of the individual who is making a vocational choice must be in terms of the vocational alternatives. Thus, concepts, understanding, and knowledge of the fields of work are essential." Williamson (165, p. 260), discussing student counseling, has said that "fewer students would select inappropriate courses if reliable statements of the requirements of the wide variety of occupations and professions open to high school students were

available.”¹ Many other such references to the importance of using occupational information could be cited. These writers are referring mainly to student counseling. For the hospital vocational counselor, the effective knowledge and use of such information is even more vital because he is primarily concerned with planning for training or placement that is compatible with physical capacities. Inadequate planning may well bring about rehospitalization and more severe illness. Moreover, he is dealing with individuals who are generally older and less resilient physically and mentally.

The amount of occupational information now available is staggering to the beginning vocational counselor. The *Dictionary of occupational titles* (147), for example, now lists more than 22,000 different occupational definitions under more than 40,000 different titles. Add to this such things as the courses offered by a variety of vocational schools, data on employment trends, and industry descriptions, and it becomes obvious that the vocational counselor cannot rely on memory or his experience with previous individual patients. Baer and Roeber (8, p. 8), in a very useful handbook on occupational information, point out that “the counselor need not be a human encyclopedia of occupational information to counsel effectively.” What he needs is a general understanding of the world of work, with its major occupational and industrial groupings, and knowledge of where to find detailed occupational information when needed and how to use it. Personal work experience and direct observation will be useful; but he cannot hope personally to cover the large area of occupational information in these ways. What the vocational counselor needs is a good occupational reference file which has a wide coverage of jobs, is classified simply enough to facilitate ready reference, and is kept current and meaningful. This chapter will concern itself with

¹ By permission from *How to counsel students*, by E. G. Williamson. Copyright, 1939, McGraw-Hill Book Co.

the setting up of such a file, with some reference to maintaining and using it. Those interested in more complete discussions of the subject should consult Baer and Roeber (8, pp. 418-473), Tyler (136, pp. 169-192), Brayfield (28, pp. 485-595), and Strang (123, pp. 526-529). Additional valuable background information is given in Dvorak (55), Paterson and Darley (99), and Paterson *et al.* (100). Perhaps the best single source on the development and application of occupational information is Shartle's study (119).

The author feels that one of the best guides for the organization of the occupational reference file is a technical bulletin published by the Veterans' Administration (154), for use in its regional office counseling sections. A reference file found to be adequate for hospital counseling services is based on a simplified version of this plan. Bennett (15, p. 53) describes an alphabetical plan for filing occupational reference materials, which some centers employing direct student use of files may favor. Eye-catching displays for student use are also advocated for some situations by Chervenik (39, p. 39). In the hospital situation, however, where both counselor and patient are using the information and the range and detail of information should perhaps be greater, an occupational code-number classification, based on the *Dictionary of occupational titles* (147) appears to be more useful.

The occupational reference file in hospital counseling has two main functions: (1) it provides specific occupational information for patients to use in the development of their vocational plans; and (2) it contributes substantially to the improvement of the counselor's competence to appraise his patient in terms of occupational demands. The reference file based on the classification system of the *Dictionary of occupational titles* necessitates knowledge and use of its contents and insures reference to its descriptions, which probably constitute the best descriptions now available in a single source. These descriptions have been written carefully in terms of action requirements on the job and are particularly

pertinent to work with patients whose physical functions are impaired.

A useful file might include the following divisions:

1. An occupational file—a set of occupational folders in three-digit DOT code sequence containing descriptive information on jobs.
2. An alphabetically arranged industry file giving more general industry descriptions.
3. An alphabetical school catalogue file.
4. An alphabetically arranged subject file including information on labor legislation, placement agencies, occupational statistics, and similar subjects.

The occupational file might include the occupational guides of the U. S. Employment Service; the interviewing aids of the War Manpower Commission; job descriptions from individual firms and insurance companies; outlines and briefs prepared by private firms in the business of supplying technical and descriptive occupational information; occupational pamphlets, registers, and monographs published by professional and trade societies; descriptions of positions by federal, state, and local civil service agencies; descriptive job materials for servicemen; materials put out by guidance and service organizations; and materials published by schools to describe jobs and careers for which they have training facilities. These are some of the kinds of materials available. Source books like those by Forrester (61, 62), catalogues such as those distributed by private supplying firms, and bibliographies of occupational information compiled by service agencies will be helpful in learning about sources for material. Much of this occupational information is free or obtainable on a small budget. Letters to firms or to other agencies will turn up much material for this division of the reference file. Any local descriptions or job analyses done as projects or written from first-hand knowledge by counselors or trainees on the staff would be filed in this division.

Once the three-digit folders have been set up, the clerical staff can easily maintain the file, provided that the coding

of new materials is done according to DOT classification and by a counselor. It is well to rotate this task among all counselors and trainees as a device to insure continued familiarity with the contents of the file and the DOT. In addition to the materials in this part of the reference file, each counselor should have a desk copy of the *Occupational outlook handbook* (146), with its current supplements.

It is important that the occupational file be complete, with coverage of occupations as broad as possible. The counselor will want to find detailed, fairly technical information for himself and readable, attractive information for his patient. Broad and detailed coverage also serves to obviate misunderstandings that may arise from limiting descriptions to purely local coverage of occupations.

The alphabetical industry file would include broad descriptions of vocational areas, for example, the food-products industry, the aviation industry, the printing occupations, hospital careers, and the teaching profession. Materials are obtainable from both government agencies and industrial sources. Better appreciation of occupational structure, industrial organization, lines of promotion, and industrial products can be gained from use of this division of the reference file by both counselors and patients.

The alphabetical file of school catalogues is extremely important and must be kept current. Older materials, although they may remain useful for some time in the occupational and industrial divisions of the reference file, are practically worthless in this file. The simplest filing arrangement is an alphabetical series of the folders for all schools, regardless of level of training or geographical location. For very large files, level and state breakdowns may be found useful. Once letters have been written to request materials and to ask for inclusion on institutional mailing lists, a steady stream of materials will arrive. Periodic surveys of this and other parts of the file are necessary to insure currency and proper filing of materials. Files that are current and well-kept probably

will be used. These surveys are good projects for assignment to particular counselors who seem to have forgotten the importance of occupational information, perhaps because of lack of knowledge of what is available, or perhaps because of preoccupation with interviewing and personality analysis.

The particular counseling service will have to decide how many schools should be covered by its file. It seems workable to have complete coverage of all levels and kinds of schools in the immediate state, all colleges in three or four bordering states, and state-sponsored and well-known institutions in all states. The coverage will also depend somewhat upon clerical help and space. The main tasks, however, are setting up the initial folders and filing the basic materials. Requesting the information consumes little time. Even one letter a day will yield a steady flow of materials. Moreover, the possibilities of using hospital volunteers to set up and maintain such files should not be overlooked by the counseling staff.

The subject file, arranged alphabetically, might include information on apprenticeship standards, wage rates in the surrounding area, safety measures in industry, and trends, predictions, and surveys of local and state employment conditions. It also should contain available materials on the use and usefulness of occupational literature. Another valuable addition to this file is the series on occupations and industries by geographical area (for example, 153), published by the Veterans' Administration in co-operation with the U. S. Department of Labor. Most recent census reports for the particular areas under consideration are also helpful. There should also be folders containing descriptive materials and brochures on available counseling, placement, and other rehabilitation services in the community. Many of these materials are free or reasonably priced.

The two main functions of the occupational reference file were cited earlier in this chapter. It should be noted, however, that occupational information may also serve to motivate a patient or to deter him from an impractical job selec-

tion, to encourage the employment efforts of the counseling personnel, and to bring both counselor and patient closer to the realities of the labor market. In counseling with patients, where such problems as physical and mental limitations, diets, drugs, and financial status are real factors, working without adequate occupational information is a distinct handicap. If patients are to make good occupational adjustments and become contributing members of society, such realities as job requirements, job satisfaction, pay, and job preparation must be taken into account in counseling. And, to do so, the vocational counselor must have, among other tools, a useful reference file.

Mention should also be made of the need to provide the patient with occupational reference material that is both readable and interesting. Brayfield and Reed (29), studying the reading level and interest level for a large amount of occupational descriptive materials from government agencies, professional organizations, and industry, found about two thirds of this material at the very difficult level of comprehension. They concluded that much of the occupational material current in 1950 did not meet the requirements for comprehension and interest that have been suggested through the years. This poses a serious problem for the hospital counselor, who will find that the majority of his patients are not able to understand material at the higher reading levels. Continuous searching for suitable materials and rewriting in some areas will be necessary.

The practice of using the facilities of other hospital services—the library and the educational, occupational, and manual arts therapy sections—to supplement vocational information from the reference file was discussed earlier in the book.² And the advantages of actual visits to schools and firms during the counseling process were also pointed out.³

² See above, pp. 45–54, 77.

³ See above, pp. 50, 66–67.

THE TEST REFERENCE FILE

In addition to its regular file of actual tests, the vocational counseling service should maintain a test reference file. Some of the purposes of this test reference file would be:

1. To stimulate interest in a variety of tests.
2. To insure awareness of the possibilities of new tests.
3. To provide a central reference place for data on the use, validation, and reliability of tests.
4. To provide source materials on tests for use in training counselors and trainees.
5. To provide a place for local reports and studies on the effectiveness of tests.
6. To provide a central place for filing additional normative data on norm groups not frequently used.

Without such a file it is easy for the unit to become fixated on a certain small battery of available test supplies and never consider the possibility of using other instruments.

A straight alphabetical filing procedure, with folders for each test, is a simple way in which to start the file. As it grows there would appear to be some virtue in having alphabetically arranged folders within broad groupings, such as general ability, interest, personality, special aptitudes, and general aptitude batteries. This arrangement may encourage greater consideration of possible tests, within areas of behavior, when the counselor is determining which tests to prescribe for a particular patient. Printed lists of tests, organized by general category, are probably more likely to lead to habitual and uncritical selection than would browsing through folders containing actual validation and use data on each test. The test reference file should also include current catalogues of test publishers and materials for ordering tests within the framework of the particular agency. Consideration should be given to purchasing a specimen set for each useful test for inclusion in the file.

The individual test folders will be as useful as they are complete. They should contain a copy of each available form

of the test; sample answer sheets used; a copy of each manual that is available for the test (keeping old ones is a useful practice for research and report purposes); normative data; available reprints of studies on the development and uses of the test (including critical articles); a complete set of scoring keys; data sheets or special profiles; procedures and prices for scoring machine-scored tests; and abstracts of pertinent materials from source books on tests (prepared by counselors and counseling psychology trainees). It is valuable for reference and training purposes to include also series of bulletins and articles on testing in general, such as those published by the Psychological Corporation and the World Book Company.

In addition there should be available source books on tests which might well include such basic books as Buros' year-books (34, 35, 36, 37), Strong (125), Fryer (63), Super (130), Blum and Balinsky (24), Anastasi (4), Wechsler (159), Terman and Merrill (132), Cronbach (41), Fryer and Henry (64), Hathaway and Meehl (74), and Bell (14).⁴

Again it would seem wise to rotate work with this file among the counselors and students to stimulate proper use of tests, discussion, and research. When a discussion of the meaning or proper use of a test arises, it is gratifying to be able to go to a single source for rather complete data and to achieve some resolution of the problem while it is still a matter of real interest. Smaller counseling services without a training function might decide to incorporate such a reference file with the regular files of test materials.

The test reference file is, of course, a file for the professional counselor, and not one for patient use.

THE DISABILITY REFERENCE FILE

Another important tool for the hospital vocational counselor is the disability file. It is useful to maintain, perhaps on

⁴ Since the preparation of this study, three valuable source books in interest testing have been written: Strong (125a), Darley and Hagenah (43a), and Layton (89a).

5 x 8 cards, abstracts of articles or sections of books on specific disability areas. The U.S. Employment Service (139) publishes interviewing guides for specific disabilities, with emphasis on physical capacities and placement considerations. These guides help the counselor to supplement his knowledge of medical terminology and treatment practices. The coverage of disability areas and the inclusion of other useful counseling information, however, are not so broad as they might be.

Development of a disability reference file can be a gradual process, with each counselor contributing from his own reference work from time to time. Specific gaps in information, after the file has been in operation for a while, might be assigned as library research projects to trainees and counselors.

One workable method of filing is the setting up of dividers with titles such as seizures, heart conditions, diabetes, skin conditions, back disabilities, amputations, and tuberculosis. The system should be kept simple to insure ready reference. Many of the references cited in the disability chapters of this analysis could be used as sources from which to start such a file.

The main purposes of the disability reference file are:

1. To assist the counselor in building a fund of medical information in all disability areas, so that he can work more effectively with patients and with other hospital personnel.
2. To provide a starting point for training new counselors in the significance of differences in disabilities.
3. To help keep counselors up to date on new developments in disability areas (which might otherwise be known only to one counselor).
4. To provide data for use with placement men and employers on the capabilities and record of successful employment of disabled persons.
5. To give information on capacities, general limitations, and suggested occupations for specific disability groups.
6. To point to the fact that much useful literature on the re-

habilitation of disability groups is found in medical, social work, physical medicine, nursing, and similar publications.

7. To inspire thought and application of knowledge of specific disabilities in the total counseling process.

This file will also supply a useful bibliography for research, articles, talks, and training conferences on vocational counseling with disabled clients. References to studies using specific tests with certain disability groups, as, for example, the one by Wiener (1963), would also be included in this reference file.

THE PROFESSIONAL PSYCHOLOGIST'S LIBRARY

Mention should also be made briefly of the desirability of having readily available within the vocational counseling service a good library of psychology books. Often the library of the hospital will not be able to purchase all the necessary texts, and it may be useful to establish a library in the service, with each counselor and trainee contributing books from his own collection for loan to other counselors. It is surprising how quickly a respectable reference library can be built up and how little clerical effort is required to set up a card index to control it. Again, if materials are accessible, more frequent use seems to be made of them than would otherwise be the case.

LIBRARY OF TAPE RECORDINGS

Another useful technique for improving counseling and counselor training is frequent use of recordings in patient counseling and staff meetings. If the service has good recording facilities and a budget that permits purchase of an adequate supply of tape, consideration should be given to the building of a library of tape recordings for use in demonstrating the particular procedures that seem to be most effective in working with specific patients in the different disability groupings.

SUMMARY

This chapter stressed the importance of good reference sources in the hospital vocational counseling service. Occupational reference files, test reference files, disability reference files, a professional library in the counseling service, and a library of tape recordings have all been discussed as having proved useful in working with disabled patients. Particular attention has been given to ways in which to establish occupational information, test reference, and disability reference files. Sources of information for the files and possible uses in the counseling process have been discussed.

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PART SIX

Conclusion

20

Areas That Require Investigation

In the preceding chapters, a number of the problems of the vocational rehabilitation counselor have been analyzed, the counselor's duties and responsibilities have been indicated, and approaches to the solution of the problems have been suggested. This analysis, however, has not attempted to provide final answers to those problems that have been discussed; nor does it pretend to have dealt with all the problems of vocational rehabilitation counseling. There are as yet many problem areas and unanswered questions to be investigated. Since the main purpose of this study is to stimulate further reading, thinking, and research, with a view toward integration of the rehabilitation counseling processes, it seems fitting to mention briefly some of the specific areas that still require analysis.

INTERPERSONAL RELATIONSHIPS

In Chapter 3 the importance of earning acceptance by the rehabilitation team, establishing status with its members, and finding the most effective level of operation for the vocational counselor within the total hospital or rehabilitation framework was stressed. To facilitate the counselor's task in establishing good interpersonal relationships it might be valuable to investigate his role as it is perceived by the physicians, social workers, occupational therapists, and other workers in the paramedical services. How do their concepts of the counselor's role compare with counselor's view of himself? This

kind of a study might be done with attitude scales. The result should enable counselors to evaluate their present counseling activities and their manner of presenting these activities to other team members. It might suggest some changes in established procedures for communicating with other staff members or the need for more effective education of other team members as to the possible contributions of vocational counseling to them.

There would seem to be a need for a study to determine which factors in the background, training, abilities, and personality make-up of present vocational counselors might differentiate between those who easily establish good interpersonal relationships and those who have difficulty doing so. In such a study, the number of contacts made with other workers, the use of the counselor by other workers, and the ratings made by other workers and other counselors might be considered as possible means of establishing which counselors are ineffective and which are effective in their interpersonal relationships. Personal data, tests, and attitude scales might produce bases for differentiating the groups. If such a study produced positive results, it would provide valuable supplements to means for predicting academic success and general personality adjustment for use in the selection of vocational counseling psychology trainees.

The need for vocational counselors to establish good interpersonal relationships outside the hospital has been emphasized. New approaches to employers might be suggested by an evaluation of employer attitudes toward hiring persons who have specific disability conditions. A check of these attitudes against actual hiring practices would be desirable and might point to needed educational programs or legislation designed to make it easier for employers to hire the disabled.

Study of the problem of how to help new counselors and trainees to develop effective interpersonal relationships as quickly as possible is needed. At the present time a very

general approach appears to be used. It requires a good deal of training time to expose new counselors to visits, lectures, team meetings, written descriptions of services, and individual case conferences, with no particular assurance that the counselor is really helped in his task of building good interpersonal relationships and knowing how to utilize them in the counseling process. Investigation might point to the need for better training methods or improved selection techniques.

COUNSELING WITH PATIENTS

Studies in several different disability areas of the optimum points of entry for vocational counselors into the total treatment process are needed. The literature and the writer's experiences have indicated that in some areas of disability and in some specific cases, the counselor, by entering at the wrong stage of hospitalization, has impeded progress in the counseling effort and may have caused the patient further emotional and even physical distress. Study of medical opinions, patients' reactions, degree of acceptance of counseling, and success of counseling as estimated by such things as amount of patient participation, success on the job, and participation in other therapies might be considered. It is difficult to get clear-cut results in problems such as this, but study is needed.

Although it seems advisable for rehabilitation counselors to avoid using tests under conditions differing greatly from those under which the tests were standardized, studies should be undertaken to determine whether or not there are differences in performance under various hospital conditions. A study of whether or not there is a general level of depression of test scores for hospitalized people or for patients in certain disability categories might be made so that the counselor will be in a better position to know what his test results mean.

In the discussion of interviewing procedures the need to evaluate patient acceptance of counseling as opposed to patient compliance with a hospital routine was pointed out.

Studies of patient acceptance of the counseling process might help to establish more firmly the need or lack of need for such procedures as allowing the patient time to consider whether or not he wishes to participate, visiting the patient first on his ward, and using short, printed descriptions of the counseling service.

Since the setting and perhaps the needs of hospitalized patients are different from those of job applicants and students, it would seem valuable to know the results of studies on the accuracy of employment and personal data given by patients. The findings might suggest the need for more use of trade tests, tool lists, and other devices to determine more accurately what experiences patients have had that may be utilized in job planning.

Attention should be given to the applicability and usefulness in the hospital of diagnostic categories that have been developed in the literature on counseling.

There would seem to be a need to study and develop the most productive items for inclusion in patient-completed interview forms and problem check lists.

A comparison of the vocational adjustment of matched groups of referred and nonreferred hospital patients would help determine the effectiveness of hospital counseling and might provide information that could be used to stimulate more referrals of patients by physicians.

Follow-up studies are needed of the general effectiveness of hospital vocational counseling in terms of such things as posthospital employment record, rehospitalization because of employment conditions, and patients' attitudes toward counseling after discharge from the hospital. Attention should also be given to possible differences in the effectiveness of the counseling between disability groups, age groups, and groups with different lengths of hospital stay.

Vocational counselors could also contribute to further study of AWOL and AMA rates and their prediction for patients in the chronic disability areas, such as tuberculosis.

Long-term research projects should be initiated to evaluate the nature of the disabled population, age and disability trends, and data on job survival for specific disabilities, taking biographical data into account. Such continuing projects should help vocational counselors to adjust their techniques to the population to be served. For example, attention will have to be given to the problems of counseling and placing older patients. Such things as the applicability of current test norms for older populations may be a problem.

S U M M A R Y

In this chapter it was pointed out that there are many unanswered problems in vocational counseling in the rehabilitation setting. Some areas in need of further research were discussed, in particular, the areas of interpersonal relationships and counseling with patients. Several possible lines of investigation were indicated. Additional research and study projects may be found in Appendix C, which contains a suggested outline for the hospital internship training of new vocational counselors and vocational counseling trainees.

PART SEVEN

Appendices

APPENDIX A

Questions to Be Considered in Other Disability Areas

It is not feasible in a book of this size to attempt to discuss all disability areas in which the vocational counselor will be active, and the decision to concentrate on certain sample areas was discussed earlier in the text. There are, however, some important questions in other disability areas, which may be useful to the counselor. Even without a more complete discussion of the disability areas themselves, the following questions will suggest matters for consideration by the vocational counselor with the physician and the other rehabilitation team members. They may also provide hints of the information and help available to the counselor.

THE BLIND AND VISUALLY HANDICAPPED

The hospital vocational counselor is not frequently called upon to work with blind or visually handicapped individuals. When he is asked to work with these persons, he will want to utilize fully the services and experience of skilled workers, who are generally employed by societies for the blind or by the appropriate state agency dedicated to problems of the visually handicapped. In hospital and rehabilitation planning, however, the counselor will be co-ordinating the efforts of his hospital or state rehabilitation team. Therefore, he needs to know what kind of information will enable him to work intelligently with the visually handicapped and what data will be needed by the experts to whom he refers his patient. The following questions, to be resolved with the physician and the other team members, may be of some assistance to the counselor:

How much visual loss does the counselee have? Does he fit the usual definition of blindness, that is, 20/200 or less central vision, with correcting glasses, in the better eye?

If the central visual acuity is better than 20/200, is the diameter of the peripheral field of vision greatly limited?

If the visual condition resulted from an accident or required surgery, how much is facial appearance affected? How aware and accepting of this is the patient?

Does the cause of blindness (diabetes, tuberculosis, accident, attempted suicide, as examples) appear to have made a difference in how the patient has accepted it, in terms of such reactions as depression, guilt, defiance, cheerfulness, resignation, anxiety, or extreme stress?

How do the family and friends react? Are they helpful to the patient in making his adjustment, or do they exhibit such behavior as pity, guilt, extreme helpfulness, fear, or abnormal curiosity?

Does the patient seem to be adjusting to the idea of loss by exhibiting sociability, competitive drive, and normal anxiety, or is he self-centered, apathetic, and intensely worried?

Has the counselee been blind since early childhood, or has he the advantage of adult frames of reference to use in visualizing experiences after blindness?

What is felt to be the cause of the present visual condition? Is the loss temporary or permanent?

If there is not complete loss of vision, is further loss or improvement likely for the patient? Are any activities or conditions likely to speed further loss?

What does the patient know about amount of loss, its permanence, likelihood of progressive loss? How does he appear to be accepting his prognosis?

What is the degree of remaining vision in terms of such matters as total blindness, travel vision, object perception, or light perception? Is the individual fully utilizing the amount of vision he has remaining?

How long has the patient had a visual disability? How suddenly did it appear? How does this seem to affect his reaction to his present state?

Is the visual disability part of another medical condition, such as malignant hypertension, which must also be considered in the vocational counseling process?

What is the status of the patient's hearing, since this will be important to his progress in his rehabilitation training program? Are the results of a complete audiometric examination available?

How much orientation and prevocational training has the patient had since becoming blind? Is he able to travel alone, or will he need travel and orientation training?

How self-sufficient is the patient in home and housekeeping skills and in self-care activities? Does he need more training in this area to feel self-sufficient and skillful in everyday activities?

Will Braille, typewriting, and handicraft work help the patient to overcome feelings of inferiority and to develop skills, dexterity, and job-placement potential?

Has the patient adequate social contacts? Is he getting experience in meeting others and taking part in organized activities? Does he have an opportunity to share his problems, achievements, and experiences with other visually handicapped persons? Is he ready to make new social contacts, or has he been pushed too quickly to make new adjustments?

Can an attempt be made to utilize past experience or to readjust in previous employment before a move is made to an entirely new field of employment?

Has the patient been made aware of the wide range of jobs in which blinded and visually handicapped persons are employed?

Is provision being made in the total rehabilitation planning for leisure activities, for example, in occupational therapy, using talking books, using recorders?

What is the best attitude for all team members to take with this particular patient in his present state of adjustment (firm kindness, support, active encouragement)?

THE DEAF AND HARD-OF-HEARING

Although the manner in which language is developed may serve to differentiate the deaf person from the hard-of-hearing individual, the two disabilities are classed together here because the kinds of information the counselor needs seem to be fairly similar for both areas. Some references that describe the problems of persons with hearing loss more completely were suggested in Chapter 9. The following questions are designed to stimulate thinking and to yield information useful to the vocational counselor:

What is the cause of the hearing difficulty? Will treatment or surgery help? Is the hearing loss likely to be progressive?

If the counselee's hearing is nonfunctional for the ordinary purposes of life, is he congenitally deaf, or has his hearing become nonfunctional after illness or an accident? How much normal acoustic experience was there prior to becoming deaf?

What is the amount of hearing loss? Kind of loss? Would a hearing aid be beneficial? Is guidance being given in the selection and use of the aid? Has the counselee accepted the usefulness and appearance of the hearing aid, or is he likely to use it only occasionally or to discard it after leaving the hospital or clinic?

Will training in lip reading be helpful to the counselee? Does he wish to participate in such training?

Has the patient faced and admitted his hearing loss, or does he bluff and pretend to hear normally? What difficulties does this lead him into? How does he react to these difficulties?

How does the counselee react to his loss of hearing (rejection, hostility, retiring behavior, overly aggressive behavior, extreme frustration, accepting attitude)?

What opportunities does the patient have for social activities? Is he discouraged, depressed, suspicious of others? How does the rehabilitation team plan to cope with this?

Is the patient aware of the fact that a variety of jobs, which do not stress communications skills, are possible for him with proper training? Does he know that personality factors, rather than the physical handicap itself, may often be the deciding factors in keeping or losing a job?

If the counselee appears dull and inattentive, is there a real deficiency, or may this be due to lack of understanding of what is desired?

Are good measures of the patient's mechanical aptitudes and dexterities available?

Can the counselee be stimulated, perhaps in occupational therapy, to develop hobbies and to meet others with similar hobby interests?

How much has the patient been told about his condition and about the need to accept it and to live as productive a life as he can? Is he looking for some special cure?

How can manual arts therapy, educational therapy, workshop training, or trade training be utilized to develop salable skills and self-confidence with this individual?

What in the opinion of the physician and other team members who have worked closely with the patient is the best way in which the vocational counselor can communicate with this client in order to establish understanding and acceptance of the counseling relationship?

What agencies and clinics for the hard-of-hearing and the deaf are available in the community to provide not only additional training for this person but also opportunities for increased social activity with other individuals with hearing difficulties?

THE PATIENT WITH PULMONARY TUBERCULOSIS

References given in Chapter 9 provide much background information that is pertinent to effective vocational rehabilitation of the tuberculosis patient. Even with the improved methods of medical and surgical treatment, these are still relatively long-term patients, and much valuable work can be done in vocational planning during the hospital period if the counselor is alert to the possibilities. The following sample ques-

tions should assist the counselor to get a picture of the patient's needs and the physician's recommendations:

What is felt to be the best time for the counselor to make the first preliminary contact to let the patient know that the counselor and the team are available to plan positively with him for his employment or training following treatment?

If the patient desires to plan, when is it likely that the counselor will be able to enter into a more concentrated vocational planning effort?

Does the patient appear to be one who may leave the treatment situation against medical advice or go AWOL from the hospital? How can the social worker and the counselor help to avoid this?

Are there personal problems (family, economic, drinking), that will be important in planning for a vocation with the patient?

Is this the first admission, or a readmission for tuberculosis? If a readmission, do any special factors stand out as likely contributors to recurrence of the disease? Job factors? Work habits? Personal habits? Environmental conditions?

What is the extent of involvement of the disease? Probable length of hospital stay? Plan for treatment? How much does the patient understand about his disease and the plan for treatment?

If the amount of disease is minimal, are there any physical limitations or work changes that will be necessary?

What is the estimated work tolerance for this patient on discharge from the hospital? What rate of increase is planned?

What seems to be the patient's emotional reaction to having the disease? Are other members of the family affected? Is there depression, lack of concern, guilt, hostility, or other reaction? How does the treatment team plan to deal with these reactions?

Is re-employment in the last job something the counselor should begin working on, since employer resistance may be strong? How realistic are early assurances of re-employment?

If surgery is contemplated, how does the patient accept this? How may this influence his reactions in early vocational counseling interviews?

How might the patient's free time be utilized in realistic prevocational work and job exploration? How active can he be? Does present utilization of free time give any clues to the patient's drives, interests, work habits, and satisfactions?

How is the patient accepted in the ward community? What role has he assumed, or been given, in relation to other patients during his relatively long period of hospitalization?

How does the patient conduct himself on passes and leaves?

What kind of home situation will the patient return to? Will he be able to observe the work tolerances and treatment prescribed by his physician?

What specific conditions in terms of such things as environmental exposures, heaviness, emotional strain, maintaining self-discipline in daily habits, and job satisfactions should be considered for this particular patient?

THE PSYCHIATRIC PATIENT

In vocational counseling with psychiatric patients such matters as the best point of entry for the counselor, amount of involvement in the patient's emotional problems, and extent of participation in therapy often present themselves to the counselor as special problems. Consideration of questions like the following, with the psychiatrist and other members of the treatment team, may help to resolve such problems for individual counseling situations:

Does the psychiatrist want the counselor to attempt vocational planning with the patient at this time, or is a screening interview, to learn about previous vocational adjustment to supplement data for diagnosis, what is desired?

Has the patient progressed enough in his therapy to be able to understand, participate in, and accept vocational planning? Should the vocational counselor accept the patient at this stage for counseling assistance?

Does the patient accept the counselor as one who will assist him in vocational planning, or does he think of the vocational counselor as another person actively engaged in therapy with him? Can the psychiatrist help to clarify this with the patient?

How much should the vocational counselor structure initial interviews with this patient to lead directly to vocational planning when the patient talks about his emotional problems and doesn't lead into vocational problems? Is it desirable with a particular patient to hear out enough of his difficulty to allow him to know that the counselor accepts him with his particular problems, so that vocational planning can perhaps proceed on a more firm footing?

If the patient appears to look to several persons for active therapy (the psychiatrist, social worker, clinical psychologist, and vocational counselor), should the counselor find the opportunity to withdraw and to begin active vocational planning again after therapy has achieved more of its goal? What is the best point of entry for the counselor with this particular patient?

How much environmental manipulation is feasible and desirable to

help assure continued adjustment, vocationally and otherwise, with this patient? Are the vocational counselor and the other team members, particularly the social worker, all working in the same direction?

What clues to motivations, interests, adjustment, and real desires to plan for a vocation are available in other therapies, for example, educational, occupational, manual arts, and the library?

In vocational planning with this patient, how much attention should be given to such things as stress on the job, level of responsibility, working actively with others, close supervision, freedom to move about, and evidence of achievement?

Is it possible to arrange activity in the hospital environment that will approach actual employment conditions, so that the patient's reactions can be observed with a view to making the best possible job placement when he is ready for discharge?

What information will be most helpful to the family, the placement official, the potential employer, or the school official in assisting the patient with his readjustment to society?

How much are interview and test data gathered in counseling colored by the patient's condition or the treatment?

THE SEIZURE PATIENT

Some sample questions to be considered in working with seizure patients are included, since this appears to be one of the more difficult areas in which vocational counselors attempt to do a good job of counseling and placement. If questions like those that follow are carefully resolved with the physician and are discussed with the placement specialist and employer, perhaps some of the employer prejudice for this disability area may be overcome:

Are the seizures of idiopathic or symptomatic origin?

What kind of seizures does the patient experience (for example, grand mal, petit mal, Jacksonian, psychomotor, or hysterical)?

What is the frequency of seizures, and is it likely that this will change under medical control? How effective is the present medical control of this patient's seizures?

Does the patient have a warning? How much? What kind? Always?

Has the patient accepted his diagnosis? How does he react to it (rejection, desire to plan, depression, anxiety)?

Are there aftereffects of the patient's seizures? How may these affect employment?

Are there medical conditions, injuries, brain damage, or other limitations to be considered in addition to the seizures?

In examining the patient's work history, does it appear that skills

and experience can be utilized without fear of injury to himself and others in the event of a seizure? Is he really limited in resuming his previous work, or is the limitation employer-imposed or self-imposed?

If work history is poor, is this likely to be due to such things as attitudes, abilities, interests, or personality factors, to the stigma attached to his seizures, to his own avoidance of dangerous conditions, to fear, or to other factors?

How does the family react to his disability? How does the patient react to his condition in relation to family feelings and responsibilities?

Is the patient's medication stabilized enough so that such reactions as drowsiness are not affecting the vocational planning or placement progress?

How important is it for this patient to avoid emotional strains, tenseness, family and economic worries, and unhappiness? How possible is it?

Is there a possibility of mental deterioration with this patient?

What specific occupational hazards need to be considered in the event of a sudden seizure, even when there is good medical control (for example, operating vehicles, high places, hot materials, acids, and machine tools)?

If there is mental dullness or sluggishness, is this established and lasting, or may it be the result of such things as medication, depression, or social mistreatment?

THE PATIENT WITH ARTHRITIS

The following sample questions to be resolved when working with arthritic patients are included largely because it is necessary to work out very careful and detailed plans if job placement is to be both satisfactory to the employer and physically acceptable to the patient:

What type of rheumatic disease is present (for example, rheumatoid arthritis, arthritis due to infection, arthritis due to rheumatic fever, arthritis due to injury, Marie-Strümpell disease, degenerative joint disease, nonarticular rheumatism), and what are the implications for physical activity now and after treatment?

Does the condition involve joints or connective tissues?

Is the condition acute or likely to be chronic? Will loss of physical capacity be progressive?

Is there deformity, or is it likely that there will be deformity? How limiting is this likely to be with this patient?

Is work capacity on the present or desired job actually impaired, or is the job within the patient's physical capacities, and the medical condition an uncomfortable nuisance he must live with? Does the patient know this? Does he accept this?

What kind of therapy is planned (physical therapy, drugs, exercise,

surgery, rest, psychotherapy)? What implications does this have for vocational planning in terms of such matters as prognosis, ultimate physical capacity, acceptance of the disease condition by the patient, best point of entry for the counselor, influence of drugs, and sources of additional information (on patient's motivation, reactions, and work habits) for the counselor?

After discharge from the hospital, will exercise and physical activity help or hinder the patient in his efforts to maintain his physical status? How much activity with this patient?

Is it important to avoid stress or emotional shock in the employment of this particular patient?

What specific parts of the body are most likely to be affected with this patient?

What is the physician's estimate of the severity of the disease relative to employment for this patient? Is he likely, for example, to have pain and stiffness but no limitation, to work regularly but produce at a lower than normal level, to miss a good deal of work, to be unemployable?

Does the family understand the patient's condition and the importance of motivation? Does it encourage the patient's determination to carry on, if this is medically wise, or does it foster dependency?

How well is the patient able to handle his daily self-care? What information can the physical and corrective therapists supply?

How important is it to avoid wet, cold, and damp working conditions? How much loss of strength and agility is there?

If work must be sedentary, should patient avoid cramped quarters? Should job allow some moving about during the working day?

What can the vocational counselor contribute to other team members (about such matters as present motivation to get well and return to work, tasks the patient has done without discomfort, abilities, and interests) from careful analysis of job history, interview notes, employer reports, and behavior in interview and testing situations?

APPENDIX B

Sample Forms Used in Vocational Counseling

VOCATIONAL COUNSELING SERVICE INFORMATION SHEET *

What Is It?

The Vocational Counseling Service is a part of the total hospital effort to help patients to reach the fullest physical, mental, social, and economic usefulness. It helps patients to plan for a job or training after they leave the hospital.

It Is Not

A required hospital activity for patients.

An employment agency, although it works with various employment services and placement men.

A relief agency; it has no funds for patients.

A fortune-telling agency attempting to predict one's future.

A service that will solve all of your problems for you.

It May Help a Patient to

Learn of many things that he can do within his physical limitations.

Consider his ambitions and desires intelligently.

Discover certain fields of work in which he is strong.

Avoid certain fields of work in which he is weak.

Learn more about occupations and industries.

Learn of occupations in which successful workers have abilities and interests similar to his own.

Learn some of the reasons why he has not had greater success in the past.

Put his spare time in the hospital to good use by knowing which edu-

* Adapted from one described by Bergen and Ward (17).

cational and occupational therapy activities may contribute to his success on a job.

Make contacts with placement and training agency representatives that will result in a job.

The Patient May Be Asked to

Complete a personal data sheet, giving many details of his past employment, hobbies, interests, etc.

Have several interviews with a vocational counselor.

Try out tests and work samples in the testing room.

Study information about various kinds of work.

Vocational Counseling Will Not Be Started Unless

The patient wants it and is willing to work with the counselor in the planning.

The ward physician feels the patient is at the point where he should start planning.

It is hoped that this will give you an idea of how the Vocational Counseling Service works. After you have had time to think over these services a vocational counselor will call on you again.

PERSONAL DATA SHEET

The information you give on the following pages will help you and your counselor in your vocational planning. Better planning can be done if you answer the questions as completely as possible. Your counselor will consider this confidential information.

Name..... Ward No.....
Last First Middle
Address..... Tel. No.....
..... Age.....
Date and Place of Birth.....

I. General Information

Describe what you hope to get out of this planning with a vocational counselor:

.....
Have you ever done job-planning with a counselor before?.....
Where and about when?.....
Do you have a job to return to?..... Do you want to change jobs?.....
Why?.....
If you must get a job quickly, give reasons:.....
.....

If you could do any kind of a job you wanted, describe what you would like best and how you think you would want to prepare for it:

.....
Why would you like this kind of a job?.....

.....
What is your present choice of a job or training?.....

.....
How certain are you that this is what you really want? Check below:
....very certainfairly certainuncertaindoubtful

If you are not working, what have you done so far to find a job?

.....
Are there activities or work in which you feel you are not very good?

.....
Are there any things that seem to cause you trouble on a job?

.....

II. Hobbies and Leisure Activities

List any organizations to which you belong. If you hold an office, state just what it is?.....

.....
What kinds of books, magazines, or articles do you enjoy reading?

.....
Check each of the activities below in which you have *often* taken part. Put two checks next to those in which you *now* take part. Add any others not on the list:

- | | | |
|--------------|----------------------|----------------------|
|Tennis |Gardening |Television |
|Golf |Boating |Brick work |
|Hiking |Singing |Movies |
|Boxing |Band |Growing flowers |
|Fishing |Radio |Landscaping |
|Hunting |Baseball |Playing cards |
|Bowling |Woodworking |Church |
|Pool |Wood refinishing |Home decoration |
|Skating |Clock repair |Stamp collection |
|Politics |Cooking |Model airplanes |
|Reading |Photography |Tinkering |
|Concerts |Art museums |Swimming |
|Drawing |Dancing | |
|Travel |Parties | |

.....
Describe what you do in your spare time that you feel is the most interesting:.....

.....

What hobbies do you have that you feel might be useful in earning a living?.....

III. Work Experience

Describe here any work you did for your parents or others while you were still in school and on summer vacations:.....

Describe all your work experience. Begin with what you do now, or with your latest job, and then work backward for the last three jobs. Do not list military experience:

1. Name of job.....Weekly take-home pay.....
Describe exactly what you did and how you did it, including tools and equipment that you used:.....
.....
.....

Name and address
of employer.....
Date you started job.....Date job ended.....
Why did you leave job?.....
What did you like about this job?.....
What did you dislike about this job?.....

2. Name of job.....Weekly take-home pay.....
Describe exactly what you did and how you did it, including tools and equipment that you used:.....
.....
.....

Name and address
of employer.....
Date you started job.....Date job ended.....
Why did you leave job?.....
What did you like about this job?.....
What did you dislike about this job?.....

3. Name of job.....Weekly take-home pay.....
Describe exactly what you did and how you did it, including tools and equipment that you used:.....
.....
.....

Name and address
of employer.....
Date you started job.....Date job ended.....
Why did you leave job?.....
What did you like about this job?.....
What did you dislike about this job?.....

List here the names of all other jobs you have ever had:.....
.....
Of all your jobs, which did you like best?.....
Of all your jobs, which did you like least?.....
Describe your feelings about working with or around other people:
.....
Do you like your supervisor, foreman, or boss to check your work? Check one:
....frequentlyoccasionallyseldomnot at all
How much salary do you feel you need to get along each month? \$.....

IV. Military Experience

Date entered active service..... Date of separation.....
Branch of service.....Highest rank.....Theater.....
Months overseas?.....Months combat?.....Months POW?.....
Wounded?.....Decorations?.....Courts martial?.....
Describe below just what you did in service, beginning with your first assignment. Give position, duties, length of time in each duty:
.....
.....
.....
List any service schools you attended. Give name of school, location, kind of course, length of course:.....
.....
Describe anything about your military service that you liked or disliked, and any duties that have helped you in civilian life, or that you think might help you in future employment:.....
.....
.....

V. Education

	Grade School	High School	College
Name of school
Location
Date left
Grade completed
Age completed
Type of course
Year graduated
If you attended high school or college, describe courses:		
		
What courses did you like most?		

What courses did you like least?.....
 In which courses did you get your best grades?.....
Poorest grades?.....
 Give grades taken over or skipped and reasons:.....

 Give here any reasons why you did not go further in school:.....

 What other activities, except school subjects, were you in while in school? Write a number below for the years you took part. Do not include hobbies or leisure time activities after you left school.

- | | | | |
|---------------------|-------------|------------------|--------------------|
|Football | ...Baseball | ...Swimming | ...Dramatics |
|Basketball | ...Band | ...Hockey | ...Student council |
|Track | ...Chorus | ...School paper | ...Boy Scouts |
|Debate | ...4-H Club | ...School play | ...Class officer |
|YMCA | ...FFA | ...Cheerleader | ...Public speaking |
|Future teachers | ...YWCA | ...Literary club | |

List here any letters, honors, awards received, or other activities in which you were active while in school:.....

List correspondence courses, trade schools, extension courses, or any other training, such as apprenticeship, on-the-job, GI Bill, rehabilitation, etc. Do not list military training.

School or firm:	Name of course:	Months:	Date ended:
.....
.....

What in your school experiences has helped you most in life?.....

VI. Family and Home Information

Single.... Married.... Divorced.... Widowed.... Separated....

If you were ever separated, divorced, widowed, or remarried, give dates

.....

Do you pay alimony or support money?..... Amount? \$.....

Number of children..... Ages

List the following information for your wife, father, mother, sisters and brothers. If deceased, indicate when. Use back of sheet if needed.

Relationship:	Age:	Education:	Occupation:
.....
.....
.....
.....

If your parents were divorced, separated, or remarried, how old were you when this happened, and did it affect you?.....
.....
Do you own your own home....Rent....Room....Live in hotel....
Apt.....?
Other housing arrangements?.....
Grew up on farm?..... In a city or town?..... Size of city?.....
If you did not live with your parents as a child, explain, giving age you left home and the reasons for leaving?.....
.....

VII. Health

Height..... Present weight..... Normal weight.....
Eye defects.....Hearing defects.....Compensation \$.....
Describe here any service-connected disability that you have:.....
.....
Any other severe disease or injuries that you have had:.....
.....
Have you been sick:.....oftenfrequentlyseldom.
State here the reason why you are *now* in the hospital:.....
.....
Dates and places where you have been hospitalized:.....
.....
Describe anything that is hard for you to do because of your present medical condition:.....
.....

VIII. General Remarks

Write below any additional information you would like the counselor to know in planning with you.
.....
.....
.....
.....
.....
.....

Please sign here.....
Date.....

PROBLEM CHECK LIST

Name..... Date.....

Everyone faces problems throughout his life. Some of these problems are difficult to solve without help. Often they are easily solved. Sometimes they are solved only after much work. Below is a list of problems with which people are often concerned. Place a check (x) in front of those problems which you have *not* been able to solve.

- | | | |
|-----------------------------|----------------------|---------------------------|
|Worn out by job |Can't save money |Limited by disability |
|Poor place to live |Bossed too much |Can't buy things |
|Meet people poorly |Lack of friends |Being away from home |
|Quarreling at home |Self-centered |Can't make up my mind |
|Poor working conditions |Need more fun |Family responsibility |
|Too much spare time |Too nervous |People against group |
|Lack of education |Getting married |Not having a home |
|Easily influenced |Hard to talk |Take things to heart |
|Religious problems |Alone too much |Need job information |
|Unsteady income |Need a job |Relatives interfere |
|Lack self-confidence |Indoor work |Watched at work |
|Work too dull |Debts |Relatives' religion |
|Job is too heavy |Children |No advancement |
|Can't pay attention |Dislike people |Social whirl |
|Act without thinking |Outdoor work |People dislike me |
|Afraid of unemployment |Careless |Can't stay in my job |
|Physical appearance |Lazy |Family occupation |
|Waste too much time |Worry |Little social life |
|Get tired too easily |Poor memory |Not understood |
|No one cares for me |Too shy |Finding right job |
|Sex difficulties |Need more money |Knowing what I want |
|How to look for a job |Poor memory |Parents' job advice |
|Expensive family |Shiftless |Need to improve |
|Different from others |A bad temper |Dislike help |

Chief problem:.....

Other problems:.....

If you care to, briefly say what you hope most to get out of life, in terms of job, happiness, position, money, enjoyments, and so forth:

.....

FORM FOR INTERVIEW NOTES

Date: Patient:
Ward: Office: Counselor:
Interview:InitialData-gatheringInterpretive
.....Counseling

Patient's Problem or Reactions

.....
.....
.....

Counselor's Interpretation

.....
.....
.....

Evidence of Psychological Movement

.....
.....
.....

Hypotheses to Be Tested

.....
.....
.....
.....
.....
.....
.....

APPENDIX C

Outline of In-service Training Program

The following outline suggests some of the points that should be covered in the hospital training of vocational counselors. It is expected that local revisions might be desirable and that revisions and additions will be in order as more experience is gained in the training of vocational counselors within the hospital setting. The suggestions below do not cover academic training and are limited to the hospital experience of the trainee. It should be noted that the projects listed in Part VI of the outline list only a few of the training experiences possible in a rehabilitation setting.

I. Beginning Orientation

The first week will probably be spent in general orientation in the functions of the particular hospital. This might include the following activities:

- A. Processing in the personnel division and receiving general orientation for new employees of the agency.
- B. Introduction to top management of the hospital, for example, the manager, assistant manager, chief of professional services, and research director.
- C. Tour of the physical facilities of the hospital, including facilities like the laboratories, morgue, and quarters, so that the new counselor will have a general idea of the total hospital operation.
- D. Introduction to the chiefs of other services and divisions, such as social service, physical medicine and rehabilitation, contact, and special services.
- E. Completion of interview and data forms similar to those used with patients, to promote familiarity with forms available and to supplement data on file in the vocational counseling service on the trainees themselves.
- F. Interviews with the Chief of the Vocational Counseling Service regarding his responsibilities and goals for the Service, and his feelings on how counselors should function in the hospital.

II. Familiarization with the Vocational Counseling Service

The remaining weeks of the first month might be spent by the trainee on the vocational counseling service, learning how it actually operates within the framework of the total hospital. This would involve some of the following activities:

- A. Learning the general philosophy of the hospital and the service.
- B. Becoming familiar with the kinds of patients referred and the sources of referral.
- C. Learning where and how various types of useful vocational counseling information can be obtained.
- D. Visiting other services in the hospital with a staff vocational counselor to actually see some of the activities in process and to learn how vocational counselors can learn from and assist these other services.
- E. Having a scheduled interview with the chief or the assistant chief of each of the major hospital services.
- F. Learning the office routine, including applications, forms, organization of files, and clerical responsibilities. Knowing the kinds of records that are used and maintained.
- G. Reading patient counseling folders to get an idea of the kind of reports and letters that are written and the ways in which vocational counseling becomes tied into the hospital and posthospital activities of the patient.
- H. Studying files of tests and test manuals; studying occupational reference and disability reference files; and filing new materials in these resource files.
- I. Becoming familiar with the provisions of the training laws administered by the Veterans' Administration and the state rehabilitation divisions.

During this first month the trainee will probably not be working with individual patients. He will spend a good deal of time observing other counselors, listening to recordings, participating in staff meetings, observing testing procedures, making ward visits with staff counselors, and asking questions.

III. General Objectives

Some of the general objectives of the training given to vocational counseling psychology trainees in the hospital might include the following:

- A. To learn the various vocational counseling approaches to different kinds of disabilities and different kinds of patients by:

1. Counseling on the various services in a planned rotation which will include such services as medicine, surgery and orthopedics, tuberculosis, psychiatry, and neurology.
 2. Studying and discussing, in staff and individual meetings, training materials and readings on counseling in specific disability areas.
 3. Helping to maintain and supplement the disability file.
 4. Meeting with ward physicians on specific disability problems and specific patients.
- B. To learn the limitations and uses of psychometric testing in the hospital setting by:
1. Giving prescribed tests in the testing room.
 2. Administering individual tests to patients.
 3. Testing patients on the wards when necessary.
 4. Discussing test interpretations with the supervisor.
 5. Using recordings of test-evaluation interviews to assess effectiveness.
 6. Helping to maintain and supplement the test reference file.
 7. Reporting on areas of testing, or on new tests, at regular staff meetings.
- C. To improve vocational counseling interview techniques by:
1. Observing interviews.
 2. Discussing interviews with fellow counselors.
 3. Using recordings of interviews.
 4. Staffing patients interviewed in the regular weekly staff conferences.
- D. To learn how the team approach works in a hospital setting by:
1. Becoming familiar with the medical and administrative organization of the hospital and the division of duties.
 2. Learning as much as possible of the basic philosophy behind the functions of each service.
 3. Attending hospital rehabilitation board meetings and meetings of the functional committee.
 4. Attending case staffings, ward rounds, grand rounds, and other meetings on the particular service on which he is working.
- E. To become familiar with the placement and counseling possibilities of agencies in the surrounding community area by:
1. Visiting agencies such as the state employment service, the state vocational rehabilitation division, the state civil service agency, and the federal civil service commission.
 2. Checking with the social service workers on agencies with which they work.

3. Meeting personnel of local college counseling bureaus and public counseling agencies in the community.
 4. Visiting representative schools and industries in the area.
 5. Studying employment trends and vocational opportunities in the area from local publications and national outlook surveys.
- F. To learn VA organization by:
1. Direct orientation by the chief of the service.
 2. Dealings on individual patients with other VA sections.
 3. Visiting the regional office counseling section, training section, educational benefits section, mental hygiene clinic, and out-patient clinic.
 4. Learning the use of VA or agency forms and applications.
 5. Orientation on agency lines of authority outside the hospital.
 6. Studying the administration of training laws and compensation benefits.
- G. To establish and maintain professional status at a high level and to improve learning and effectiveness by:
1. Participating in the American Psychological Association and other professional organizations, such as the regional psychological association, the state psychological association, the local vocational guidance association, and the local rehabilitation association.
 2. Attending university institutes and meetings when possible.
 3. Attending occasional meetings of other groups interested in rehabilitation, such as personnel managers associations and industrial training directors associations.
 4. Subscribing to professional journals such as the *Personnel and guidance journal*, *Journal of counseling psychology*, and *Journal of applied psychology*.
- H. To participate in research aimed at improving counseling methods by:
1. Carrying on research in the service under the supervision of university consultants and the chief of the service.
 2. Participating in critical evaluation and discussion of research projects of other trainees and staff members.
 3. Utilizing the resources of the hospital, college, and local libraries to evaluate current research in counseling for presentation at staff meetings.
 4. Suggesting and planning new problems for research from actual experience in vocational counseling in the hospital.
- I. To learn to present effectively, in written and oral form, the results and progress being made in vocational counseling with individual patients by:

1. Practice in writing effective referral memos and letters to other services and agencies, with evaluation of these by the chief of the service.
2. Practice in writing reports for the clinical record.
3. Practice in writing consultation sheets to be sent to the ward physician.
4. Presentation of cases before hospital board meetings.
5. Preparing complete illustrative cases for use by new trainees.
- J. To help carry the load of referrals in the service by doing actual vocational counseling. The extent of this participation will be determined by the level and past experience of the individual trainee.
- K. To become well versed in occupational information and job-requirement data by:
 1. Learning the organization of the occupational reference file and the sources of such materials.
 2. Maintaining the occupational reference file for a definite period of time.
 3. Studying materials on physical and environmental demands in representative occupations and learning to relate these demands to the physical and environmental limitations of patients.
 4. Making a sample job analysis.

IV. Supervision of Trainees

Each trainee probably should be assigned to a different staff vocational counselor for each period of rotation. In addition, he should have at least weekly supervisory interviews with the chief of the service. As an aid in keeping records of supervision and in providing the trainee with constructive criticism, the chief of the service should review completed counseling summaries and make written comments and suggestions that can be used as a basis for the weekly supervisory interviews. When university consultants are available to the service, a good part of their consulting time should be reserved for private visits with the trainees. This should allow the trainee to obtain independent judgments of his progress, to take advantage of the knowledge of the consultants, and to air his views on the progress he is making and the training that he feels he needs. It will also give the consultants an opportunity to evaluate trainee progress and attitudes and to make suggestions to the chief of the service.

V. General

- A. There should be a good deal of flexibility in a proposed training plan in the hospital, since the level of training and experience and the ability of each trainee will govern, to a large extent, the

emphasis that should be placed on individual aspects of the training program.

- B. Weekly staff meetings should allow ample time for discussion of patients being counseled, using recordings of interviews whenever possible. This should allow a maximum of interplay between consultants, trainees, and staff.
- C. Occasional seminars, including the staffs of the vocational counseling service, the regional office counseling section, and the clinical psychology service (and/or mental hygiene clinic) should provide a useful means of maintaining good relationships and exchanging ideas on counseling and research.
- D. Rotating trainees in different disability areas is probably more effectively managed on a time basis than on a caseload basis.

VI. Suggested Projects for Vocational Counseling Trainees

To contribute to the trainee's knowledge of vocational counseling psychology and to the fund of useful material available to the vocational counseling service as a whole, some of the following trainee projects might be useful:

- A. An analysis of vocational objectives selected in the counseling service over the last few months, with emphasis on such things as range of different objectives, stereotypy of choices, vagueness or exactness of plan, and comparison of objectives with the job distribution of the local civilian population. Such a project would require the trainee to refresh himself on the *Dictionary of Occupational Titles* and should give both the trainee and the counselors an over-all picture of the kinds of occupational choices being made.
- B. An analysis of patients active in vocational counseling during a recent given period, with emphasis on such matters as age trend, period of service, the sources of referral, types of disability, and shifts of direction within these divisions. This should familiarize the trainee with the kind of vocational counseling load he can expect in this kind of a setting, and it should help the staff to keep informed as to its patient population and to know where efforts should be directed in explaining functions to other services.
- C. A study of the available occupational reference materials and a comparison of these with materials available in other counseling centers. This should help the trainee to know where he can find information for his patients and how to write for additional materials. It should also add to the service's file and help to assure its currency.
- D. A survey of the test reference file for currency and adequacy. This

should help refresh both the trainee and the staff and should lead to additional reading of the literature and, perhaps, additional reports for the file.

- E. Investigation of the possibility of increasing group meetings with patients, emphasizing the value of information giving as an adjunct to psychotherapy and, perhaps most important, as a pre-counseling device for the development of attitudes that will permit a more mature approach to individual vocational counseling.
- F. A survey of the feelings of other services as to what each feels is its main contribution to the total patient effort. This will facilitate trainees meeting with many members of other services and should help the staff as a whole to understand the attitudes of representatives of other services as they are expressed in case conferences.
- G. The development of a pamphlet or short release describing vocational counseling services to patients. This might help the trainee to understand thoroughly the goals of vocational counseling and to consider some of the best ways of presenting them to patients and others.
- H. A study of patient's attitudes when they first come to the service, with the hope of discovering how fully patients have been informed or misinformed at the time of referral to the service.
- I. An analysis of testing-room records and monthly reports to learn the current patterns of testing, including use or neglect of available tests. This should help the trainee to think constructively about choosing tests on a prescription basis rather than following a stereotyped pattern with all patients. This should also give other staff members a chance to look over the selections they have been making.
- J. An analysis of interviewer's observations and comments, with attention to such things as completeness, shallowness, meaningfulness, stereotypy, willingness to predict future counseling events, and planning for the next interview. This might help both trainees and staff counselors to avoid falling into rigid patterns and to keep more meaningful counseling notes.
- K. A survey to determine what new additions have been made to the educational therapy and hospital libraries and what kinds of equipment are available that might have significance in vocational counseling. This should serve to keep services like educational therapy in the minds of counselors and should keep the staff informed as to new courses and materials that are available for patient use.
- L. A survey of motor skills and dexterities involved in various occupa-

tional therapy and manual arts therapy activities. This should help trainees and staff to realize the uses that vocational counselors can make of these services and should make special requests for progress reports more meaningful.

- M. The development of a brief reference sheet for staff members of the provisions and benefits of laws administered by the agency.
- N. The development of a questionnaire to determine such things as where the patient likes to be contacted first, how he reacts to familiarity from a counselor, what he thinks he learned in the counseling process, or the value of testing to him. This should help the trainee to consider carefully the dynamics of the counseling situation.
- O. A visit to the local employment service offices to report back on current job openings, difficult patients to place, and reactions to referral letters from vocational counselors. This should help the trainee to establish effective working relationships on a personal basis with employment service placement men.
- P. The development of information on various lengths of stay for different kinds of disabilities. This will help the trainee to learn of the kinds of information available in the offices of the hospital registrar and the medical librarian and will give staff members better estimates of amounts of time likely to be available for work with different kinds of patients.
- Q. A personal analysis by the trainee of his behavior as a counselor. By using recordings and consulting with other counselors, the trainee might find it instructive or informative to develop a description of himself, with special attention to such things as ease of talking with patients, talking too much or too little, permissiveness, amount of control and direction in the interview, missing cues, and asking questions that are too specific.
- R. The use of oral trade tests on a group of patients to determine whether or not they were helpful in developing new clues or in corroborating the patient's work descriptions. This may help the trainee to develop the habit of checking on the validity of claims of experience when patients give work data.
- S. The development of a meaningful test profile worded in patient language. This might help the trainee to think in terms of how the patient is likely to react to test interpretations given in psychological terminology.
- T. The development of, and participation in, research projects. If this can be co-ordinated with current academic work, it will serve to tie in hospital training with the academic program in a more meaningful way.

These suggestions for the training of vocational counseling psychologists in the hospital have been limited to the work situation. It is felt that many of these suggestions for work practice are applicable to the training programs for counselors in other agencies. Although vocational counselors in the state programs, for example, do not have as easy access to the other paramedical services that the VA hospital vocational counselor does, the state counselor has closer touch with community resources over a larger geographical area and has more follow-up contacts with his patients. Both kinds of counselors need familiarity with the kinds of services and techniques dealt with throughout this book. Arrangements to provide training for new counselors may differ, but the same basic problems and areas need to be covered.

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*Glossary of Medical Terms**

acne vulgaris common acne; a chronic inflammatory disease of the sebaceous glands, occurring most frequently on the face, back, and chest

ancillary subservient or subordinate, auxiliary

aneurysm a bulge caused by pressure behind a thinner or weaker portion of an artery

angina pectoris the intense, brief, suffocating pain in the chest brought on by exertion, excitement, or any temporary situation in which the flow of blood through the coronary arteries is insufficient

anterior poliomyelitis inflammation of the anterior horns of the gray substance of the spinal cord

arteriosclerosis hardening of the arterial walls

asymptomatic showing no symptoms

atopic dermatitis allergic eczema

bradycardia slow heart action

bronchoscopy examination of the bronchi through a tracheal wound or through a bronchoscope

carcinoma a malignant new growth made up of epithelial cells tending to infiltrate the surrounding tissues giving rise to metastases

cardiophobia morbid dread of heart disease

cardiovascular pertaining to the heart and blood vessels

carditis inflammation of the heart

catheterization the employment or passage of a catheter or tubular instrument into a chamber (for example, to measure pressures in the heart)

chemotherapy the treatment of disease by administering chemicals which affect the causative organism unfavorably but do not injure the patient

cholecystectomy surgical removal of the gall bladder

colostomy the operation of forming an artificial opening into the colon

contact dermatitis an acute allergic inflammation of the skin caused by

* These definitions have been adapted from Dorland (52) and *Webster's New Collegiate Dictionary* (158).

contact with various substances of a chemical, animal, or vegetable nature

contracture a contraction; a shortening or distortion, as from shrinkage of muscles or scars

coronary thrombosis a blood clot in a narrowed coronary artery cutting off the blood supply to a portion of the heart

cystoscopy direct visual examination of the urinary tract

decubitus ulcer an ulceration caused by prolonged pressure in a patient confined to bed for a long period of time; also called pressure sores

dermatitis a general term including redness, irritations, eruptions, blistering, weeping of the skin, pimples, and boils

dermatoses, occupational stigmata, injuries, ulcerations, inflammations, and proliferations of the skin, caused by contact with substances encountered in the course of an occupation

diabetes insipidus a metabolic disorder marked by great thirst and passage of a large amount of urine with no great excess of sugar

diabetes mellitus a metabolic disorder in which the ability to oxidize carbohydrates is more or less completely lost due to faulty pancreatic activity, especially of the islets of Langerhans, and consequent disturbance of the normal insulin mechanism

diastole relaxation or expansion of the heart

dyspnea shortness of breath

eczema an inflammatory skin disease with vesiculation, infiltration, watery discharge, and the development of scales and crusts

embolism a sudden blocking of an artery or vein by a clot or obstruction which has been brought to its place by the blood current

endocarditis inflammation of the lining membrane of the heart

endocrinology the study of the internal secretions

erythema a morbid redness of the skin due to congestion of the capillaries

essential hypertension higher-than-normal blood pressure occurring without a demonstrable cause

exacerbation increase in the severity of any symptoms or disease

folliculitis inflammation of a follicle or follicles (small excretory or secretory sacs)

furunculosis the diseased condition that accompanies the appearance of a crop of boils

gangrene massive death or necrosis of tissue

gastrectomy the removal of the whole or a part of the stomach

gastroenterology the study of the stomach and intestines and their diseases

glycosuria sugar appearing in the urine

hematology that branch of biology which treats of the morphology of the blood and blood-forming tissues

Hodgkin's disease a painless, progressive, and fatal enlargement of the lymph nodes, spleen, and general lymphoid tissues, which often begins in the neck and spreads over the body

hyperglycemia excessive sugar in the blood

hypertension higher-than-normal blood pressure

hypertensive heart disease enlargement and eventual weakness or failure of the heart resulting from prolonged high blood pressure

iatrogenic disease doctor-induced disease

Jacksonian seizures seizures due to focal injury or lesion of an area of the motor cortex of the brain

keratosis any horny growth, such as a wart or callosity; any disease attended by horny growths

laryngology that branch of medicine which has to do with the throat, pharynx, larynx, nasopharynx, and tracheobronchial tree

lesion any morbid change in the structure of organs or parts

leukemia a fatal disease of the blood-forming organs characterized by a marked increase in the number of leukocytes in the blood, with enlargement and proliferation of the lymphoid tissues of the spleen, lymphatic glands, and bone marrow.

lichen planus an inflammatory skin disease with wide, flat papules

lymphoma any tumor made up of lymphoid tissue

marginal antisepsis focusing attention on the individual until the margin is reached where the group should be protected against the effects of the malbehavior of the individual

Marie Strümpell disease a condition in which the entire spinal column is enclosed in a bony encasement due to ossification of the spinal ligament

melanoma (malignant) a malignant tumor, usually developing from a nevus and consisting of black masses of cells with a marked tendency to metastasis

melanosis a condition characterized by abnormal pigmentary deposits

metastasis the transfer of disease from one organ to another organ or part not directly connected with it

mycotic dermatitis dermatitis caused by yeast infections

myocardial infarction damage to an area of the heart deprived of proper blood supply

myocarditis inflammation of the heart muscle

neoplasm any new and abnormal growth, such as a tumor

nephrectomy excision of the kidney

neurocirculatory asthenia cardiac neurosis, irritable heart, soldier's heart, disordered action of the heart, effort syndrome

neurodermatitis a neurotic dermatitis

neurology that branch of medical science which deals with the nervous system, both normal and in disease

oncology the sum of knowledge concerning tumors; the study of tumors

ophthalmology the sum of knowledge concerning the eye and its diseases

orchiectomy excision of one or both testicles

orthopedics orthopedic surgery; that branch of surgery which is specially concerned with the preservation and restoration of the skeletal system

oscillometer an instrument for measuring oscillations of any kind, especially the changes in the volume of pulsation in the arteries

osteogenic sarcoma a general term for tumors occurring in bone and arising from bone cells of osteogenic tissue

otolaryngology otology and laryngology considered as a single specialty

otology the sum of what is known regarding the ear

palliative effect serving to ease without curing

paramedical alongside the medical

paraplegia a paralysis of the lower limbs, associated with impaired control of the bladder and bowel

pericarditis inflammation of the exterior membrane or sac containing the heart

phantom limb a sensation of the limb still existing after it has been amputated

physiatrist a physician who specializes in physical medicine

placebo an inactive substance or preparation, formerly given to please or gratify a patient; now also used in controlled studies to determine the efficacy of medicinal substances

polyuria increase in the amount of urine

proliferation the reproduction or multiplication of similar forms, especially of cells and morbid cysts

prosthesis an artificial part, such as an eye, leg, or denture

pruritis intense itching, a symptom of various skin diseases

psychosomatic having bodily symptoms of a psychic, emotional, or mental origin

pylon a temporary artificial leg

pyogenic producing pus

rehabilitation the restoration of the handicapped to the fullest physical, mental, social, and economic usefulness of which they are capable

renal conditions kidney conditions

rheumatic fever a disease, probably infectious, associated with the presence of hemolytic streptococci in the body, beginning with an attack of sore throat, pharyngitis, and cervical adenitis, followed by chills, rapid rise in temperature, prostration, and painful inflammation of the joints. There is usually cardiac involvement

rheumatoid arthritis a chronic disease of the joints marked by inflammatory changes in the synovial membranes, articular structures, and by atrophy of the bones

sarcomas tumors which are often highly malignant

sclerotic hardened or thickened

seborrheic dermatitis an inflammatory disease of the skin characterized by yellowish, greasy scaling of the skin of the scalp, mid-parts of the face, ears, and supraorbital regions, and usually accompanied by itching

sinus arrhythmia irregularity of heart rate, characterized by recurring periods of gradual slowing down and speeding up

stenosis narrowing of the size of an opening (heart valves)

systole contraction of the heart

tachycardia rapid heartbeat

teratoma a tumor containing fetal remains congenitally derived

transverse myelitis inflammation of the spinal cord or the bone marrow which extends across the cord

urology that department of medicine which has to do with the urine and the urinary tract

vascular pertaining to vessels

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